

American College of Preventive Medicine

Policy Committee Report February 2005

Chair: Mark Johnson
Vice Chair: Chris Armstrong

Staff: Mike Barry

Since reporting to the Board in November 2004, the ACPM Policy Committee and policy staff have focused on: (1) developing a long-term legislative strategy to strengthen preventive medicine residency funding, (2) reviewing policy resolutions, (3) reviewing and commenting on the proposed Medicare coverage determination to allow payment for tobacco cessation counseling; (4) participating in the 2004 Interim Meeting of the AMA House of Delegates, and (5) organizing a session at Preventive Medicine 2005 focused on the 109th Congress and preventive medicine opportunities.

Advocacy for Preventive Medicine Residency Training

ACPM has continued targeted advocacy aimed at assuring and bolstering funding for preventive medicine residency (PMR) training programs. ACPM's focus has been on developing a long-range legislative strategy to establish a line-item in the federal discretionary budget devoted to PMR training, a la the Children's Hospitals Graduate Medical Education Fund legislation in 1999. Since the November meeting, ACPM has convened a small steering committee to oversee the initiative, continued forging alliances with partners, drafted a framework for the legislative strategy, prepared a one-page advocacy document for use on Capitol Hill, and conducted numerous visits to Capitol Hill to meet with staff of targeted congressional members. The steering committee will meet again at ***Preventive Medicine 2005***. ACPM hopes to draft legislative language in the coming months and seek appropriate legislative vehicles and sponsors for introducing a bill during the current legislative session. (See Attachment A for background documents.)

ACPM also continues to advocate for funding under HRSA's Title VII health professions education programs. The final FY 2005 appropriations bill signed by the President included level funding (from FY 2004) for public health, preventive medicine and dental public health programs, notwithstanding a 0.8% across-the-board cut. ACPM has begun its advocacy for Title VII funding for FY 2006, working with several health coalitions to advocate for the highest possible allocation in the Budget Resolution.

Policy Resolutions

ACPM issued a call to members for policy resolutions in its December 16 issue of *ACPM Headlines* and on the ACPM web site. To date, ACPM has received three resolutions for consideration by the Policy Committee at its upcoming meeting:

- 01-05 – Bioequivalence of generic drugs in the international marketplace

- 02-05 – Eliminate underage alcohol consumption
- 03-05 – Opposing cooperation of physicians and health professionals in torture

All three resolutions have been vetted through the Policy Committee via the listserv. See Attachment B for copies of the three resolutions. The Policy Committee and, if recommended by the committee, the Board of Regents will take action on these resolutions at their meetings in Washington, DC.

Proposed Medicare Tobacco Cessation Counseling Rule

ACPM developed and submitted comments to the Centers for Medicare & Medicaid Services (CMS) in response to its Proposed Coverage Decision Memorandum for Smoking and Tobacco Use Cessation Counseling. The proposal, which could take effect within 90 days if the rule is approved, would cover smoking cessation programs for beneficiaries who have smoking-related illness, such as heart disease, lung disease, and cataracts, or who take medications that are adversely affected by tobacco. ACPM was strongly supportive of the proposal, but also urged CMS to cover smoking cessation services for other smokers who meet certain mental health service coding criteria. See Attachment C for a copy of ACPM's comments.

AMA House of Delegates

ACPM was active at the AMA House of Delegates 2004 Interim Meeting in December in Atlanta. Although ACPM did not directly sponsor any resolutions, ACPM's delegates and preventive medicine section council representatives actively testified before reference committees and on the House floor on a variety of Reports and Resolutions that were relevant to preventive medicine. The testimony was instrumental in the acceptance, rejection, or modification of many policies. A report from ACPM's delegate, Fred Nobrega, was shared with the Policy Committee in November. To read about the final House action on any of the reports/resolutions, go to <http://www.ama-assn.org/ama/pub/category/13320.html>. Also of note, AMA unveiled its new advocacy agenda at the meeting. Among its seven priorities is "Improving public health through...promoting healthy lifestyles...eliminating health disparities."

Preventive Medicine 2005 Session

ACPM has organized a plenary session at its upcoming annual meeting titled "The 109th Congress and Preventive Medicine Opportunities." Two influential congressional members—Senator Tom Harkin (D-IA) and Representative Ralph Regula (R-OH)—will provide an overview of current congressional priorities, the prospects for prevention-oriented legislative proposals, and the key barriers and facilitators to their successful passage. Participants will gain a better understanding of the federal legislative process and how the preventive medicine community can participate and be more influential in the process.

Continuing / New Business

- See Attachment D for the ACPM policy compendium since the November Board meeting.
- ACPM prepared a letter requesting a meeting between the ACPM leadership (and leaders of other preventive medicine societies) and the AMA Board of Trustees Executive Committee

and identified as a key agenda item AMA support for GME funding of preventive medicine residencies. The letter was co-signed by all four preventive medicine organizations and sent under the aegis of the Section Council on Preventive Medicine (see Attachment E).

- The Prevention Practice Committee (PPC) has nearly completed its work on the inaugural sunset review process in an effort to ensure that ACPM policy remains current. At its last meeting, the ACPM Board adopted the recommendations of the PPC for seven of ten policy statements that had expired or were about to expire. Since the last Board meeting, the PPC has generated its recommendations and rationale for the final three expired practice policy statements—Screening for Skin Cancer, Skin Protection from Ultraviolet Light Exposure, and Screening Mammography for Breast Cancer. The Board will make a final decision on these three policy statements at its meeting in February. See Attachment F for the full sunset review. The Policy Committee will be involved in the 2005 sunset review.
- The Action Items from the November 7, 2004 Policy Committee meeting and action taken on each item can be found at Attachment G.

ACPM Policy Committee Report, February 2005
LIST OF ATTACHMENTS

- Attachment A** ACPM's legislative strategy for funding PMR programs: One page handout, framework, and steering committee minutes
- Attachment B** ACPM resolutions submitted for consideration at *Preventive Medicine 2005*
- Attachment C** ACPM's comments on the CMS proposed decision re: coverage for tobacco cessation counseling
- Attachment D** ACPM's policy compendium, October 2004 – January 2005
- Attachment E** AMA Section Council on Preventive Medicine letter to AMA leadership
- Attachment F** 2004 ACPM policy sunset review
- Attachment G** Action items from the November 7, 2004 Policy Committee meeting

Attachment A

ACPM's legislative strategy for funding PMR programs: One page handout, framework, and steering committee minutes



Preventive Medicine is the only medical specialty that does not receive dedicated federal funding for Graduate Medical Education (GME)—an important reason for the growing shortage of much-needed Preventive Medicine specialists.

ACTION NEEDED: ESTABLISH A LINE-ITEM APPROPRIATION DEDICATED TO PREVENTIVE MEDICINE RESIDENCY TRAINING

Preventive Medicine is a medical specialty that requires three years of graduate medical education: (1) Clinical training; (2) Academic public health training; (3) Field training

There are 3 specialty areas within Preventive Medicine (PM)

- General Preventive Medicine / Public Health (GPM/PH)
- Occupational Medicine
- Aerospace Medicine

Services provided by Preventive Medicine specialists:

- | | |
|---|---|
| •Disease prevention and health promotion:
e.g. obesity prevention, tobacco cessation | •Infectious diseases: surveillance, vaccination,
children’s health |
| •Public Health leadership: local, state, and federal | •Bioterrorism preparedness |
| •Public service: most GPM/PH specialists are
employed in government | •Health care quality: preventing medical errors |
| | •Cost containment: clinical prevention, policy research |

Supply of Preventive Medicine specialists:

- There are 79 Preventive Medicine residency programs, down from 90 in 1999
- There are 356 specialists enrolled in PM residency programs, down from 434 in 1996
- Preventive Medicine specialists represented 0.8% of all physicians in 2002, down from 2.3% in 1970
- A significant number of positions that are best filled by Preventive Medicine experts remain occupied by inadequately trained non-specialists

Federal Funding for Preventive Medicine training:

- No Medicare GME financing. Because Preventive Medicine specialists focus on population health and public programs, income from direct patient care is generally not available
- Residency programs cobble together funding from disparate sources. General Preventive Medicine / Public Health (GPM/PH) programs are at the greatest disadvantage. Residents are often forced to subsidize their own training
- Title VII of the Public Health Service Act provided only \$1.4 million in FY 2004 to GPM/PH programs, down from \$2 million in 2002, supporting only 7 residency programs and 25 residents
- At least \$28.7 million is necessary to fund GPM/PH residency training demand. This would provide funding for 400 GPM/PH residents annually

Background:

- Qualified physicians provide more effective public health leadership (Kahn, 2003)
- The expertise of preventive medicine specialists matches identified gaps in public health infrastructure (Lane, 2000)
- Increasing federal support is an effective way to expand training (Glass, 2000)
- The Council on Graduate Medical Education and the Institute of Medicine have recommended increasing the supply of Preventive Medicine specialists

ACPM Legislative Strategy Framework:
GME funding for Preventive Medicine Residency programs

STRATEGY: Line item funding for Preventive Medicine Residency training programs

- Discretionary funding; line item separate from Title VII
- Administering agency not specified
- Authorizing language as amendment to related bill
- Coordinated by ACPM steering committee

GOALS:

I. Build support / minimize opposition

- a. ACPM: members should be informed that this strategy capitalizes on a current political opportunity; there is extensive discussion in the PM community regarding competencies and training structure which should not be introduced into this funding strategy
 - > Action: create informational materials to be distributed to ACPM membership
- b. AMA: partner for political power
 - > Action: meet with AMA executive leadership; work through ACPM liaison
- c. HPNEC: avoid opposition due to “zero sum” perception
 - > Action: ensure that line item is outside of Title VII. Identify key stakeholders and provide education and information
- d. ASPH: avoid opposition due to low perceived value of PM
 - > Action: meet with ASPH leadership, educate and inform
- e. Other organizations.
 - > Action: Develop and prioritize comprehensive list
 - > Action: Gather letters of support from prominent, well placed individuals (eg. CDC, AHRQ, NIH, HRSA, AMA, APHA leaders)
 - i. COGME
 - ii. AAMC – AAMC/CDC have a cooperative agreement
 - iii. CDC – AAMC/CDC have a cooperative agreement
 - iv. AMA
 - v. APHA
 - vi. M/PHI (Medicine and Public Health Initiative); AMA & APHA
 - vii. AAPHP
 - viii. Public health officials (ASTHO, NACCHO)
 - ix. Partnership for Prevention
 - x. Trust for America’s Health

II. Gather bipartisan support in congress

- a. Lobby members of congress; seek publicity
 - > Action: develop informational materials for distribution, including one page summary, letters of support, and cost effectiveness vignettes
 - > Action: identify high priority members who are likely to provide strong support or opposition
 - > Action: arrange meetings with emphasis on health committees’ membership; seek possible sponsors
 - > Action: develop grass-roots support – ACPM, APMR, others

III. Draft legislation

- a. Calculate level of DME to be requested
 - i. Note that this will need to be clarified before preparing education and lobbying materials
- b. Determine need and suggest process for calculating IME

- c. Determine nature of request
 - i. Funding for residency training
 - ii. Funding for study of residency training
 - 1. cost effectiveness
 - 2. workforce needs
 - iii. Combined request: funding for a study and funding for training

ACPM Ad Hoc Steering Committee on PMR Funding (2004-2005)

Conference call #1

December 16, 2004 – 2:00 to 3:35 p.m. ET

Minutes

Participants: Kathleen Acree, Mike Barry (staff), Dan Blumenthal, Jim Boex, Doug Campos-Outcalt, Ron Davis, Dorry Lane, Richard Lewis, Jessica Nunez, Daniel Shodell (resident)

1. Welcome and introductions
2. Role of the steering committee: Mike Barry facilitated discussion of the steering committee's role. The committee will provide oversight and problem-solving capabilities, determine and review strategy, and assist with developing resources for the ongoing legislative strategy.
3. Strategy Framework: Dan Shodell reviewed the draft strategy framework that was distributed to committee members prior to the meeting. Discussion focused on workforce, differentiating the field, scope of the legislative strategy, cost issues, and effective arguments to make the case for increased funding. There was also brief discussion regarding the decision to seek a line item appropriation that is completely separate from title VII.
 - a. Workforce needs, in terms of filling physician leadership roles in local health departments: In Michigan, for example, each local health district requires that the top two positions include at least one physician, but there are too few qualified applicants to meet the need. The advantages of physician leadership in public health were briefly discussed, including preparedness. It was also noted, however, that caution must be observed to avoid perception of elitism, in that we are saying that effective public health leaders must be physicians.
 - b. To differentiate the field for the purpose of educating members of Congress, anecdotes should be offered in addition to describing the basic training and competencies that distinguish PM specialists from other physicians or other public health leaders. Doug Campos-Outcalt noted, for example, that non-PM trained physicians take some time to "catch up" when performing as public health leaders. The concept of "domain of practice" should also be used to emphasize the appropriate role for PM specialists. A limited exchange about cross-training in PM and fellowship models pointed to underlying controversy within the specialty that needs to be addressed. The importance of PM physicians in assuring delivery of clinical preventive services was also discussed as an angle, although there was not agreement about the value of this approach versus a focus on strengthening the public health infrastructure.
 - c. Scope of the legislative strategy: The committee discussed the general legislative approach and what will be requested of Congress. In addition to funding PM residency training, there may be a need to request funding to sponsor an independent study that will examine workforce needs, possibly cost effectiveness issues, PM competencies, and value added. This issue continues to be a topic for discussion. A draft proposal for a workforce study was shared with committee members prior to the meeting. The group debated whether ACPM should push for a study of the public health physician workforce that could answer many of the questions about need, value added, and shortages prior to advocating for the establish of line-item funding. The group agreed that ACPM should be nimble in its approach and not allow a lack of evidence to thwart potential funding opportunities. Members urged ACPM to move forward with its strategy and seek potential legislative vehicles, while at the same time continuing to compile its evidence (including perhaps through a funded study of the PM workforce).

- d. Cost issues: The committee discussed the idea that it may be prudent to ask for a carve-out from existing money, rather than new money. For example, full funding would represent only 0.6% of an existing \$5B expenditure on preparedness and infrastructure. This approach, however, may increase political opposition from current recipients of these existing funds. In addition, economic data regarding the effect of PM specialists on spending should be collected. This could be framed as an issue of return on investment for the federal government. Cost effectiveness issues may not have enough data or may not be in our favor and should be avoided.
- e. Our most compelling arguments involve public health physicians and clinical preventive medicine. An additional argument may focus on staffing the public health infrastructure that has already received federal support.

Suggested action items:

- Explore whether there are existing data that show how many local public health jurisdictions require physician leadership; NACCHO and CDC public health workforce reports may have this information
- Examine whether the data can be parceled by state and congressional district to target legislators who are directly affected by shortage of qualified public health physician leaders
- Collect anecdotes that can be used as talking points: Examples of errors made by non-PM trained public health physicians, accomplishments specific to PM, etc. (Doug Campos-Outcalt and Kathleen Acree may have initial information)
- Develop a pithy articulation of PM competencies that differ from the competencies of a non-PM MD/MPH physician
- Find literature regarding “domains of practice” and apply this to PM (Jim Boex may have initial information on this topic)
- Try to find a published GAO report from about 1 year ago regarding percent of recommended preventive services successfully delivered among Medicare population; use this to argue need for PM as primary education for providers
- Compile cost-effectiveness data and other economic studies of component programs within PM; frame an argument as return on investment to present to legislators (avoid cost effectiveness arguments)
- Compile examples of PM-trained physicians in qualified leadership positions (or track a cohort of PM trainees), their role in the health system, and important population health outcomes achieved under their leadership.
- Identify and gather other external data to support our case

4. Legislative funding model: Jim Boex and Richard Lewis discussed recent progress in developing a methodology to calculate how much money should be requested for PM GME. In discussion with AAMC, there is no indication that we will need to make a request for indirect GME. To calculate direct GME costs, the average per resident amount (PRA from the 15th COGME report) should be used: \$71,648. If we continue asking for funds to train 400 residents, the total request will be for \$28.7M.

Action items:

- The steering committee will need to determine how many residents should be included in a request for line item appropriation

5. The meeting adjourned at 3:35pm.

Attachment B
ACPM resolutions submitted for consideration at *Preventive*
Medicine 2005

American College of Preventive Medicine – Policy Resolution # 01-05

Title: Bioequivalence of Generic Drugs in the International Marketplace
Introduced By: Halley Faust, MD, MPH, FACPM
Date: 12/9/04 (Revised 1/18/05)

Whereas, in the international arena generic drugs are generally less expensive and therefore more readily available than brand-name drugs, particularly for HIV/AIDS and malaria control, and

Whereas, many organizations such as the World Health Organization and Doctors without Borders use generic drugs whenever possible in their valliant efforts to control disease, particularly in lesser developed countries, and

Whereas, some of these generic drugs have not been tested for bioequivalence or effectiveness compared with the original patented drugs, and therefore some patients may be getting ineffective treatment while enduring the risks associated with the drugs, therefore be it

RESOLVED, that the American College of Preventive Medicine urges international health care providers, non-governmental organizations, and the World Health Organization to require either (1) proof of bioequivalence of generic drugs substituted for brand-name drugs, or (2) data that show the effectiveness of non-bioequivalent generic drugs, before adding these drugs to the formularies they use for treatment of diseases around the world.

American College of Preventive Medicine – Policy Resolution # 02-05

Title: Eliminate Underage Alcohol Consumption
Introduced By: John Nelson, MD, MPH, FACPM
Date: 1/11/05

Whereas, approximately 11 million American youth under the age of 21 drink alcohol and 7 million of them are binge drinkers, and

Whereas, underage drinking is a factor in nearly half of all teen automobile crashes which is the leading cause of death among teenagers, and linked to two-thirds of all sexual assaults and date rapes; and

Whereas, alcohol consumption contributes to youth suicides, homicides and fatal injuries, and

Whereas, on average, a child takes their first drink before age 12 and youth who use alcohol before age 15 are four times more likely to become alcoholics than adults whose first drink is at the legal age of 21, and

Whereas, the brain goes through dynamic change during adolescence, and alcohol can seriously damage long- and short-term growth and cognitive and intellectual and social development processes, and

Whereas, the AMA and the AMA Alliance, collaborating with the AMA Office of Alcohol and Other Drug Abuse, have created an Action Team on Alcohol and Health: An Initiative to Eliminate Underage Drinking, with the intent of involving practicing physicians from around the nation, be it therefore

RESOLVED that the American College of Preventive Medicine (ACPM) actively opposes underage drinking by working toward a comprehensive community-based environmental approach that includes local and state policies and medical services, and be it further

RESOLVED that the ACPM supports public health/environmental policies to curtail underage and high-risk drinking, including banning underage young people from entry into bars, increasing alcohol excise taxes, reducing or eliminating drink specials, reducing/controlling alcohol outlet density and requiring keg registration, mandating server and seller training and enforcement, and be it further

RESOLVED that the ACPM designate a member(s) to participate on the American Medical Association Action Team on Alcohol and Health, and

THEREFORE, a signed copy of this resolution will be forwarded to the American Medical Association's House of Delegates.

American College of Preventive Medicine – Policy Resolution # 03-05

Title: Opposing Cooperation of Physicians and Health Professionals in Torture
Introduced By: Erica Frank, MD, MPH, FACPM
Date: 1/30/05

Whereas, Physicians and other medical personnel serving in non-combat roles are bound by international law to treat wounded combatants from all sides, to care for injured civilians, and are required to care for enemy prisoners and to report any evidence of abuse of detainees¹; and,

Whereas, The Geneva Convention relative to the Treatment of Prisoners of War, U.S. Army regulations, and the War Crimes Act require all military personnel not to engage in and to report acts of abuse or torture;² and,

Whereas, The Geneva Convention relative to the Treatment of Prisoners of War requires military medical personnel to provide prisoners monthly health inspections, a system to request medical assistance, and proper medical treatment;³ and,

Whereas, The World Medical Association states that physicians should not participate in or facilitate torture or other forms of cruel, inhuman and degrading procedures of prisoners or detainees in any situations;⁴ and,

Whereas, American Medical Association policy states that “Torture refers to the deliberate, systematic or wanton administration of cruel, inhumane and degrading treatments or punishments during imprisonment or detainment. Physicians must oppose and must not participate in torture for any reason.... Physicians should help provide support for victims of torture and, whenever possible, strive to change the situation in which torture is practiced or the potential for torture is great”;⁵ and

Whereas, It has been documented since the spring of 2004 that the U.S. military medical system in Guantanamo Bay, Afghanistan and Iraq failed to protect detainees’ rights to medical treatment, failed to promptly report injuries or deaths caused by beatings, failed to report acts of psychological and sexual degradation, and sometimes collaborated with abusive interrogators and guards⁶; therefore be it

1 Bloche MG and Marks JH. When Doctors Go to War. NEJM 2005: 353; 3.

2 Geneva Convention Relative to the Treatment of Prisoners of War. Accessed at <http://www.unhcr.ch/html/menu3/b/91.htm>.; United States Army Regulation AFJ131-304. Accessed at www.army.mil/usapa/epubs/multi_services_1.html.; War Crimes Act of 1996[18USC Section 2441] Accessed at <http://www2.uakron.edu/law/war%20crimes%20Act%20of%201996.doc>

3 Geneva Convention Relative to the Treatment of Prisoners of War. Accessed at <http://www.unhcr.ch/html/menu3/b/91.htm>.

4 World Medical Association Codes of Ethics. Accessed at www.iit.edu/departments/csep/PublicWWW/codes/coe/World_Medical_Association_International_Code_of_Medical_Ethics

5 American Medical Association Resolution E-2.067 at www.ama-assn.org.

6 The Fay Report. www.c-span.org/pdf/armyabughraib.pdf ; Lifton, R.J. Doctors and Torture. NEJM 2004: 351; 415-6; Miles, SH. AbuGhraib: Its Legacy for Military Medicine. Lancet 2004;264;725; Bloche MG and

RESOLVED, That the ACPM condemns any participation in, cooperation with, or failure to report by physicians and other health professionals the mental or physical abuse, sexual degradation, or torture of prisoners or detainees; and be it further

RESOLVED, That the ACPM supports the rights of physicians and health professionals to be protected from retribution for refusing to participate or cooperate in abuse or torture in military settings and be it further

RESOLVED, That the ACPM urges schools and programs responsible for the education of physicians and health professionals to include training in ethical conduct and internationally recognized codes of professional behavior.

Attachment C

**ACPM's comments on the CMS proposed decision re: coverage for
tobacco cessation counseling**

View Public Comment for Smoking & Tobacco Use Cessation Counseling (CAG-00241N)

Commenter: Barry, Michael

Title: Deputy Director

Organization: American College of Preventive Medicine

Date: 01/21/2005

Comment:

On behalf of the American College of Preventive Medicine (ACPM), I am submitting comments on the Proposed Coverage Decision Memorandum for Smoking and Tobacco Use Cessation Counseling (CAG 00241N) issued by the Centers for Medicare and Medicaid Services (CMS). ACPM is the national professional medical society for physicians whose expertise and interest lie in disease prevention and health promotion. ACPM's more than 2,000 members are engaged in preventive medicine practice, research, and teaching. ACPM advocates for the specialty of preventive medicine and for national policies that promote health and prevent disease.

ACPM strongly supports the December 23, 2004 announcement by CMS proposing coverage for tobacco cessation counseling services under Medicare. The decision by CMS is well-grounded in the evidence base, and providing this coverage will have a significant, positive impact on the health of millions of seniors for many years to come.

ACPM's specific comments are grouped into three categories below: treatment covered; smokers covered; and providers who can deliver the counseling. In short, ACPM urges CMS to adopt a final rule that would provide full coverage for tobacco cessation counseling for the two groups identified in its original proposal (smokers who have a smoking-related condition or who are taking a medication affected by smoking) PLUS coverage of cessation counseling as a mental health service for other smokers who meet specific coding criteria, as defined below.

TREATMENT COVERED

It is critical that Medicare beneficiaries have access to the full spectrum of tobacco cessation services, including behavioral interventions and pharmacotherapies. While the College recognizes that the original petition did not address pharmacotherapy for tobacco cessation, we urge CMS to ensure that the implementation of the counseling benefit is done in such a manner as to maximize the availability and impact of both counseling and pharmacotherapy services. ACPM is aware that, beginning in January 2006, prescription pharmacotherapies for tobacco cessation will become available to all Medicare beneficiaries under the Medicare Modernization Act (MMA) of 2003, and we applaud that upcoming change. When implementing the MMA prescription drug provisions related to FDA-approved cessation drugs, we urge CMS to ensure access to over-the-counter pharmacotherapies that are available via a physician's prescription (e.g., "legend" transdermal nicotine patches).

Also, ACPM in general supports the scope of cessation services proposed in the decision memo. However, we urge CMS to find a mechanism to ensure coverage of smoking cessation services for seniors who might require overnight stay in a hospital or some other residential

facility during the course of treatment (e.g., when a patient becomes suicidal while attempting to quit smoking).

Finally, ACPM supports access to comprehensive, evidence-based tobacco cessation services within all federally-funded health care programs (e.g., Medicare, Medicaid, FEHBP, federally qualified health centers, rural health centers, etc...). Consistent with ensuring that evidence-based treatment services are available through all federally-funded programs, we urge CMS and HHS to fully implement all the recommendations of the cessation National Action Plan (*Preventing 3 Million Premature Deaths, Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation*) developed by the Subcommittee on Cessation of the Interagency Committee on Smoking and Health and submitted to Secretary Thompson in February 2004. The current decision by CMS is a small part of this overall strategy to combat the devastating toll of tobacco use on the American public. The entire action plan, if implemented, would have an historic impact on tobacco use rates in the United States and would help more than five million smokers quit and save over three million lives. Some of the action plan can readily be addressed administratively (much like the action taken by CMS on counseling for Medicare) while other provisions will require legislative authority and budgetary resources to execute (e.g., adequate and sustained funding for the national telephone quitline network).

SMOKERS COVERED

ACPM endorses CMS' proposal for Medicare coverage of tobacco cessation counseling for smokers who have a smoking-related condition or who are taking a medication affected by smoking. However, ACPM believes that it is critical for all Medicare beneficiaries who smoke—including smokers who have not yet developed overt symptoms or illness related to smoking—to have access to effective, comprehensive smoking cessation services. The sooner these beneficiaries have access to these services, the more likely they are to quit smoking and to avoid the multitude of diseases and illnesses attributable to tobacco use.

We recognize, however, that CMS is restricted in its authority to administratively cover services that are purely preventive in nature. As such, we urge that CMS add coverage of cessation counseling as a mental health service for smokers who meet ANY of the following definitions:

- Tobacco Use Disorder (305.1) in the section on Mental Disorders in the World Health Organization's International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM);
- Tobacco Dependence Syndrome (F17.2) in the World Health Organization's International Classification of Mental and Behavioural Disorders (ICD-10); or
- Nicotine Dependence (305.10) and Nicotine Withdrawal (292.0) in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

ACPM recognizes that Medicare will pay for only 50% of the expenses for mental health services. However, even 50% coverage will go a long way toward ensuring Medicare beneficiaries who smoke get the services they need to help them quit.

PROVIDERS WHO CAN DELIVER CESSATION COUNSELING

ACPM strongly supports the CMS proposal that counseling may only be provided by individuals trained in tobacco use cessation counseling. Of course, the promulgation of a final decision in this regard will require that CMS work with experts and stakeholders in the tobacco control

community to define the appropriate level of training required, and ACPM stands ready to help CMS with this effort, as needed.

The College believes that the need for documentation of qualifications and quality control in the treatment of tobacco dependence is undeniable for a variety of reasons, including: the increasing number of effective treatment options and the need for competent providers who understand and can effectively deliver these services; new medications and combination therapies for tobacco dependence with higher risk profiles than nicotine replacement products, requiring a keen understanding of the contraindications, side effects, and drug interactions; and the increase in funds now available for tobacco cessation (e.g., tobacco tax revenues, settlement funds, health plans, and soon Medicare) which means payers for these treatment services want to know they are buying services being administered according to evidence-based guidelines.

Most health professions' specialties require some type of certification. These include diabetes educators, asthma specialists, alcohol and drug addiction counselors, health and fitness instructors, health educators, and many other health professionals. In contrast, few clinicians have been trained to provide effective medical or behavioral interventions specifically for nicotine dependence. Individuals who do treat tobacco dependence are not required to have specialized training in tobacco treatment. This contrast is striking, considering that tobacco use continues to be the leading cause of preventable death and disability in this country.

Hence, ACPM urges CMS to consider, perhaps as a demonstration program, the creation of a national training and certification program for specialists who treat tobacco dependence. The College has a more detailed proposal on this concept which it would be happy to provide to CMS.

Attachment D
ACPM's policy compendium, October 2004 – January 2005

YEAR	NUMBER	TYPE	TITLE	SOURCE	EFFECTIVE
2004	050	H	Sign-on letter to House/Senate urging co-sponsorship of "STOP" Underage Drinking Prevention Act	National Alliance to Prevent Underage Drinking	10/04/2004
2004	051	H	Sign-on letter to House/Senate urging public health representation in US trade negotiations	Center for Policy Analysis on Trade and Health	10/29/2004
2004	052	F	ACPM position statement: Hospital Privileges for Preventive Medicine Physicians	ACPM Policy Committee	11/07/2004
2004	053	H	Sign-on letter to House L-HHS-E approp subcom urging support for the Senate mark for FY 2005 AHRQ funding	Friends of AHRQ	11/08/2004
2004	054	H	Sign-on letter to House/Senate L-HHS-E approp subcoms urging highest possible CDC appropriation for FY 2005	Research to Prevention	11/19/2004
2004	055	G	ACPM/ACOEM/AsMA/JCPMRD comments on proposed CEPH criteria revisions	ACPM GME Committee	11/15/2004
2004	056	X	Sunset Review: Recommended Actions for Expired ACPM Practice and Public Policy Statements (1996-1999)	ACPM Prevention Practice Committee	11/07/2004
2004	057	D	AMA Resolution: Patient Delivered Partner Therapy	AAPHP	11/07/2004
2004	058	C	ACPM Resolution: Allowing Non-Physician Members in ACPM	ACPM Ad Hoc Committee on Non-Physician Membership	11/07/2004
2004	059	C	ACPM Resolution: ACPM Medical Student Section	ACPM Finance Committee	11/07/2004
2004	060	C	ACPM Resolution: Administrative Home for Doctors Against Handgun Injury	ACPM Management	11/07/2004
2004	061	C	ACPM Resolution: New Goal for ACPM Strategic Plan	Bob Harmon, ACPM President	11/07/2004
NOT POLICY			ACPM Comments on the USPSTF draft, "Screening for Genital Herpes"	USPSTF	
2004	062	G	ACPM Comments to AAMC Title VII Reauthorization Committee	ACPM	12/09/2004
NOT POLICY			ACPM Comments on the USPSTF draft, "Screening for Childhood Overweight"	USPSTF	
2005	001	G	ACPM Comments on the Medicare proposed rule re: smoking cessation counseling coverage	ACPM	01/21/2005
2005	002	H	Sign-on letter to CMS re: Medicare's proposed smoking cessation counseling rule	Partners for Effective Tobacco Policy	01/21/2005
2005	003	H	Sign-on letter to President and Congress urging increased PH funding through Section 550 budget allocation	Coalition for Health Funding	02/01/2005

A = Practice Policy Statements; B = Public Policy Statements; C = ACPM Resolutions; D = AMA Resolutions; E = Coalition/Joint Statements; F = Position Statements; G = Written Comments; H = Endorsements and Sign-On Letters; I = Congressional Letters and Statements; J = Testimony and Quotations; K = Patient Education Statements; X = Internal

Attachment E

AMA Section Council on Preventive Medicine Letter to AMA Leadership

AMA Section Council on Preventive Medicine

American Association of Public Health Physicians • American College of Occupational and Environmental Medicine • American College of Preventive Medicine • Aerospace Medical Association • American Academy of Insurance Medicine • American College of Medical Quality • American Society of Addiction Medicine • Association of State and Territorial Health Officials • Undersea and Hyperbaric Medical Society

c/o American College of Preventive Medicine
1307 New York Ave., NW, Suite 200
Washington, DC 20005

January 18, 2005

J. James Rohack, MD
Chair
AMA Board of Trustees
515 N. State Street
Chicago, IL 60610

Dear Dr. Rohack:

On behalf of the Section Council on Preventive Medicine, we are requesting a meeting with the AMA Board of Trustees' Executive Committee to discuss issues of mutual interest to the preventive medicine community and to the AMA. It is our understanding that the AMA Executive Committee meets with the various specialty groups on a rotating basis every few years. It has been several years since the preventive medicine leadership has met with the AMA executive leaders, and we are looking forward to the opportunity.

As you know, preventive medicine is very much in the forefront of health care these days, with more attention being paid to disease prevention and health promotion, evidence based medicine, quality improvement, terrorism and emergency preparedness, emerging threats like SARS, avian flu, and influenza pandemic, and vaccine shortages. AMA, with the help of our preventive medicine organizations, has been a leader in bringing the healthcare community together around many of these issues to effect change. We were very pleased that the Board of Trustees included "Improving Public Health" as one of the seven priorities listed in its Health Care Advocacy Agenda for 2005. We look forward to discussing new ways we can collaborate with the AMA to accomplish that goal.

One of the most important issues that our specialty is facing, however, is the erosion of support for preventive medicine residency training. Our organizations, led by the American College of Preventive Medicine, are pursuing legislative solutions at the federal level to strengthen funding for preventive medicine residency training programs. Unfortunately, very few preventive medicine residency programs are able to access Medicare GME financing, and support from other federal sources is deteriorating. Thus, the pipeline of preventive medicine physicians is eroding at a time when these specialists' skills and expertise are needed more than ever to address some the nation's most pressing health problems. We would like to discuss ways that the AMA can help support such a legislative strategy.

Letter to Dr. Rohack

January 18, 2005
Page 2

Likewise, our specialty societies are committed to supporting the AMA in its efforts to increase membership and enhance its national credibility and influence. We believe AMA's explicit commitment to help strengthen preventive medicine training will go a long way toward boosting AMA stature and membership numbers among preventive medicine physicians.

We look forward to coming together in the near future to begin this dialogue. Please contact Mike Barry of the American College of Preventive Medicine (202-466-2044, x 106 or mab@acpm.org) about scheduling a time to meet with the preventive medicine leadership.

Sincerely,

Russell B. Rayman, M.D.

Russell Rayman, MD
Executive Director
Aerospace Medical Association

Robert G. Harmon

Robert G. Harmon, MD, MPH, FACPM
President
American College of Preventive Medicine

ARVIND K. GOYAL

Arvind Goyal, MD, MPH
President
American Association of Public Health
Physicians

Timothy J. Key

Timothy J. Key, MD, MPH, FACOEM
President
American College of Occupational and
Environmental Medicine

cc: John Nelson, MD, MPH
Michael D. Maves, MD, MBA

Attachment F
2004 ACPM policy sunset review

Recommended Actions for ACPM Practice **and Public Policy Statements (1996-1999)**

Reference #	Policy Title	Recommended Action and Rationale
1	Cervical Cancer Screening <u>Practice Policy Statement</u>	RECOMMENDATION: <u>Retain</u> , with intent to revise. RATIONALE: The <u>ACPM recommendations are still valid even though the</u> policy does not deal with new developments in cervical cytology, i.e. computerized re-reading of slides, and liquid thin-prep smears. While none of these methods is fully tested or in widespread use, liquid thin-preps in particular are growing in popularity. For triennial screening these approaches are probably acceptably cost-effective, but are clearly wasteful of resources for women screened more often than that. We might want to caution against that, but also recommend in favor of using one of these techniques in women who are screened less often than recommended. There is also the matter of HPV testing: its role is still under investigation, but we should probably comment about it in our policy. I should also confess that I feel that the existing policy is slanted in favor of over-screening, and that we should scale down to a simple triennial screening recommendation from coitarche or 18 whichever comes first. (C. Schechter)
2	Screening for Skin Cancer <u>Practice Policy Statement</u>	RECOMMENDATION: <u>Retain, with intent to revise.</u> RATIONALE: <u>The core recommendations remain sound, but there is new information regarding skin screening including the use of non-physician providers and skin self-examination (SSE). A randomized trial of population screening for melanoma is underway in Queensland, Australia involving 44 communities and 560,000 adults is underway, and results may significantly impact our recommendations. (R. Ferrini).</u>
3	Screening Mammography for Breast Cancer <u>Practice Policy Statement</u>	RECOMMENDATION: Reaffirm for 5 years. RATIONALE: While there has been considerable controversy about the validity of the clinical trials on which mammography policy and practice has been based, the core recommendation of the ACPM policy remains largely supported by the prevention community, and probably by the evidence as well. Some specific statements in the policy, which were true when it was written, are now out of date, <u>but these are peripheral and do not, in my view, warrant taking the effort to revisit the whole thing. (C. Schechter).</u> <u>In Nov. 2004, the Board of Regents referred this recommendation back to the PPC to consider aligning it with the USPSTF recommendation.</u> <u>Revised RECOMMENDATION: Archive, with intent to revise.</u> <u>RATIONALE: Upon closer review of the ACPM policy statement and in consultation with members of the Board of Regents, ACPM's policy differs enough from the latest USPSTF mammography screening recommendations, that it should be archived until it can be revised.</u>
4	Screening Asymptomatic Women for Ovarian Cancer <u>Practice Policy Statement</u>	RECOMMENDATION: Reaffirm for 5 years. RATIONALE: Still valid. The USPSTF recently updated its recommendation on ovarian cancer screening and continued to recommend against it. No new studies have been published that would change the recommendation. Results of the NCI's PLCO screening trial (Prostate, Lung, Colon, and Ovarian) won't be available for several years yet, so a 5-year time frame for reconsidering this statement is

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		probably about right. (L. Kinsinger)	
5	Screening for Prostate Cancer in American Men <u>Practice Policy Statement</u>	RECOMMENDATION: <u>Retain</u> , with intent to revise. RATIONALE: The basic recommendation is still valid but the statement needs to be updated to (1) cite more current evidence and (2) reassure concerned parties that ACPM's position is current. The statement gets cited a fair amount, but there may be many who wonder whether the College's stance has changed in the face of 6 years of new evidence. (K. Sherin)	Deleted: Archive
6	Skin Protection from Ultraviolet Light Exposure <u>Practice Policy Statement</u>	RECOMMENDATION: Reaffirm for 5 years. RATIONALE: <u>The basic recommendation is still valid, but the statement needs to be updated to include more recent formulations of physical sunscreens, actual use patterns of sunscreens (e.g. the failure to apply enough and re-apply), a bit about sunglasses and their role in ocular protection, and adverse effects. A discussion of use of sunscreen and sun protection for occasional extreme exposures versus long-term lower level exposure should be included. There is also some evidence that there are different genetic/environmental pathways to melanoma and that sun protection may be more effective for some than others. Perhaps a companion Public Policy Statement would be drafted recommending national comprehensive skin prevention programs such as occurred in Australia and which reduced the epidemic of skin cancer there. This initiative included the initiation of an accurate monitoring system for all skin cancers, education for the public and healthcare professionals about skin cancer incidence, prevention and early detection, and legislative initiatives such as occupational standards and national standards for sun-protective products. (R. Ferrini)</u>	Formatted: Font: Bold Formatted: Left
7	Strengthening Motor Vehicle Occupant Protection Laws <u>Public Policy Statement</u>	RECOMMENDATION: <u>Retain</u> , with intent to revise. RATIONALE: <u>This</u> is a very important prevention topic and our contribution is unique. <u>Enough</u> has changed in this area to warrant updating of the background information, and to add additional items like booster seats for older children, the LATCH system for child safety seats, enforcement of driving under the influence, etc. The recommendations would not change significantly, but the public policy statement as it currently stands is somewhat outdated. (A. Chabra)	Deleted: Pending review. Formatted: Font: Bold Deleted: Archive Deleted: I think this Deleted: I believe enough
8	Tobacco-Cessation Patient Counseling <u>Practice Policy Statement</u>	RECOMMENDATION: <u>Retain</u> , with intent to revise. RATIONALE: Although the policy is not inconsistent with current medical/scientific evidence, it is a bit dated. For example, the burden estimate and prevalence estimates are old, there is one new NRT now available, agency names have changed, and quitlines are now available. This policy addresses an extremely important topic, since tobacco is the leading preventable cause of death among Americans. ACPM provides an important contribution since there is a current emphasis on increasing clinician provision of these counseling interventions. I think ACPM would be remiss to not have a tobacco cessation counseling policy in place for a sustained period of time given the public health impact of tobacco and the increased emphasis on provider counseling. On the other hand, having a dated policy makes it appear as if ACPM is not completely current with the science. (C. Husten)	Deleted: Archive Deleted: ¶
9	Perimenopausal and Postmenopausal Hormone Replacement Therapy	RECOMMENDATION: Archive, with intent to revise. RATIONALE: The policy requires a drastic update in light of the 2002 and subsequent publications from the WHI. The ACPM	

	Practice Policy Statement	statement recommends that physicians counsel EVERY perimenopausal woman about the benefits and risks of HRT and helps the patient arrive at an individually-appropriate risk profile and medication decision. Its content is balanced; e.g., it cites the important HERS results, which are the basis for the WHI. It states that the WHI results will become available in 2007--that timetable obviously was accelerated, and many ancillary studies from the WHI have been published (dementia, etc). (G. Omenn)
10	Folic Acid Fortification of Grain Products in the U.S. to Prevent Neural Tube Defects Public Policy Statement	RECOMMENDATION: <u>Retain</u> , with intent to revise. RATIONALE: Several articles have been published during the past 5 years that indicate decreases in the rates of infants born with neural tube defects, suggesting the fortification of foods with folic acid is decreasing birth defects. However, these articles also suggest that the HP2010 goals for knowledge and use of folic acid and decreases in neural tube defects may not be met without increased activity by health care providers and public health practitioners. Physicians can and should play a critical role in informing women to take folic acid prior to conception. There is additional evidence that folic acid may have a role in decreasing other types of birth defects besides neural tube defects. Additionally, the most current references in the current ACPM statement were citations from 1999. (J. Guillory)

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Attachment G

Action items from the November 7, 2004 Policy Committee meeting

**ACPM Policy Committee Meeting
November 7, 2004
Renaissance Hotel, Washington, DC**

ACTION ITEMS

MOTIONS PASSED BY THE COMMITTEE

1. The committee recommends that the word “epidemics” be replaced with “disease outbreaks” throughout the Hospital Privileges for Preventive Medicine Physicians statement.

ACTION: Action was accomplished.

2. The committee recommends that the Board of Regents adopt the Hospital Privileges for Preventive Medicine Physicians statement as presented to the committee in the briefing materials with the amendment noted in #1 above.

ACTION: The statement was adopted by the Board of Regents by a 6 to 4 vote.

3. The committee recommends that the Hospital Privileges for Preventive Medicine Physicians statement be adopted as a supplement to ACPM Policy # 2004-009(C) to implement the existing policy.

ACTION: The statement was codified in ACPM’s policy compendium [2004-052 (F)] as a supplement to Policy # 2004-009(C).

4. The committee recommends that ACPM amend its Policy Development and Implementation process to further delineate the sunset, review, and prioritization procedures for keeping ACPM policies current. Specifically, the process should outline steps to ensure that users recognize the status of statements in which the position is maintained but the supporting data/evidence is out of date and that users are referred to the USPSTF for the latest evidence reviews.

ACTION: ACPM has not yet updated its Policy Development and Implementation process, but has implemented the process in the on-line policy compendium for those expired/expiring policy statements recently reviewed by the Prevention Practice Committee.

5. The committee recommends that ACPM endorse the resolution, “Advocating Secure National Vaccine Policy,” sponsored by the American Association of Public Health Physicians and submitted to the AMA, with the following amendments: “Resolved, That our AMA advocate and support in requiring the U.S. Government to assume responsibility for ensuring production, quality assurance and timely distribution, at cost to the U.S. Government, of sufficient quantities of those Vaccines recommended by the Centers for Disease Control to U.S. population at risk.”

ACTION: The ACPM Board referred the resolution to the Executive Committee and advised the ACPM delegates on appropriate language to support at the AMA House of Delegates (HOD) meeting. ACPM representatives at the AMA HOD meeting supported the principle in concept. An amended version of the resolution was approved by the HOD.

6. The committee recommends that ACPM support in concept the resolution on patient delivered partner therapy (PDPT), sponsored by the American Association of Public Health Physicians and submitted to the AMA.

ACTION: The Board of Regents approved in principle the resolution on patient delivered partner therapy (PDPT) and authorized ACPM's delegates to seek amendments at the AMA House of Delegates meeting to streamline the resolution. ACPM representatives supported the principle in concept at the HOD meeting. The resolution was referred to the AMA Board of Trustees.

ACTIONS REFLECTING A SENSE OF THE COMMITTEE

7. Further discuss the idea of an ACPM policy statement on antibiotic resistance with Arthur Frank to narrow down the possible scope of the paper, approach Eileen Yamada as a potential author for the statement, and report back to the committee at or before its February 2005 meeting.

ACTION: No action to date.

8. Continue to pursue ACPM's legislative approach to establishing a line item in the federal discretionary budget for PMR training and establish a subcommittee of the Policy and GME committees to advise the process and help develop the strategy.

ACTION: ACPM has continued to advocate for its approach on Capitol Hill and convened a steering committee in mid-December to oversee the effort.

9. Request a meeting between ACPM leadership (and leaders of other preventive medicine societies) and the AMA Board of Trustees Executive Committee and include as a key agenda item AMA support for GME funding of preventive medicine residencies.

ACTION: ACPM took the lead in drafting and sending such a letter on behalf of the AMA Section Council on Prevention Medicine.

10. ACPM should support Ron Davis' campaign for re-election to the AMA Board of Trustees.

ACTION: ACPM has committed \$5,000 to Dr. Davis' campaign and is assisting the Michigan state medical society in managing his campaign.