American College of Gastroenterology  
Board of Governors Meeting Minutes  
Grand Hyatt Washington, Washington D.C.  
April 20, 2007  
8:00 a.m.-3:30 p.m.

1. Call to Order

Approval of minutes from Board of Governors meeting held October 22, 2006, Venetian Hotel, Las Vegas, Nevada. Chair, Francis A. Farraye, M.D., FACG and Vice Chair, Samir Shah M.D., FACG welcomed the attendees.

2. President / President-Elect Comments and Report to Governors  
   David A. Johnson, M.D., FACG and Amy Foxx-Orenstein, D.O., FACG

David A. Johnson, M.D., FACG began by reviewing the College’s committee activities from the past year.

   a. National Affairs  
      - Has taken a leadership role in the ASC issue and is cautiously optimistic
   b. Educational Affairs  
      - New regional courses in New York City and Chicago as well as Saturday with GI Experts courses - Governors should work on mobilizing people to attend
      - Working to create sedation courses to help solve the problem of fellows coming through without sedation training
   c. FDA Related Matters  
      - Position paper on FDA alerts and understanding the FDA
   d. Practice Management  
      - Working with ASGE to create clinical benchmarking module
   e. Training  
      - Preparing for GI Jeopardy and Trainees’ Forum
      - Working to get fellows on the committee to engage early
   f. Public Relations  
      - Has built a fruitful relationship with the American College of Obstetricians and Gynecologists (ACOG) to get the word out to women on the importance of colon cancer screening
   g. Patient Care  
      - Working on an extension of the SmartBrief e-mail newsletter called Patient SmartBrief which will allow patients to get some of their questions answered more efficiently
      - Has taskforce looking at the ACG quality measures on P4P and to create standards to evaluate P4P programs
- Communicating with the American College of Cardiology and the American Heart Association about the use of anti-platelet agents and risk factors for GI bleeding. Working on a method to profile these patients.

h. Women in Gastroenterology
- Extending professional activities for women in Gastroenterology
- Addressing family issues related to women in the field

i. Pediatric Gastroenterology
- Working to address physical and sexual abuse against children at an early age so that they are less affected as adults

j. International Relations
- Focusing on getting gastroenterologists involved and interfaced with the international community

k. Archives
- Creating 75th Anniversary book for the College’s 75th Anniversary this year

Dr. Johnson also challenged individual states to take an active role in colon cancer screening initiatives, noting that bills successfully passed will open the door for others.

Dr. Amy Foxx-Orenstein, D.O., FACG expressed her excitement to work with the Board of Governors and the entire College in the coming year.

3. RUC / CPT
   R. Bruce Cameron, M.D., FACG

R. Bruce Cameron, M.D., FACG presented on expected CPT changes for GI in 2007. He noted that CT colonography will not be in the book this year. Identified issue for follow-up: The communication Governors send out should include a follow-up reminder to an earlier ACG communication urging the recipient to complete the practice expense survey. ACG staff will check with the AMA as to what is allowed to be communicated.

4. ASC Issues / Understanding Site of Service
   Colin Roskey – Alston Bird

ACG consultant, Colin Roskey from the firm of Alston Bird reviewed the history of Congressional interest and legislation on ASCs as well as the August 2006 CMS proposed rule, its effect on GI, and ACG’s response to it. In response to a question, he confirmed that once the rule is finalized, the only option for response is legislation. He also emphasized that the more “noise” ACG can generate from Congress to CMS on this issue, the better off we will be. He noted further that ACG has been focused on having a data-driven analysis and response.

5. What a Democratic Controlled Congress Means to GI
   Martha Kendrik – Patton Boggs
ACG consultant, Martha Kendrick from the firm of Patton Boggs, reviewed the legislative outlook for the 110th Congress. She began by looking at the Democratic leadership and make-up of key Congressional committees with jurisdiction over healthcare and a review of the issues at the top of the healthcare agenda – the Prescription Drug User Fee Act, the SGR, and universal coverage. She noted that ultimate passage of Screen for Life will be challenging because of pay-go requirements, aversion by some to a statutory fix for a narrow procedure and that ACG should respond by emphasizing the preventive benefit and utilization. For success, she urged the College to work towards getting at least 200 co-sponsors in the House and at least 60 in the Senate. She also noted that key proponents of the legislation are needed in the Congressional leadership.

6. **State Legislation for Mandatory Colorectal Cancer Screening**  
*W. Elwyn Lyles, M.D., FACG and Richard M. Farleigh, M.D., FACG*

W. Elwyn Lyles, M.D. FACG reviewed his successful efforts to get a colon cancer screening benefit mandate passed in Louisiana and Richard Farleigh, M.D., FACG reviewed the history of a similarly successful campaign in Alaska. He noted that every state has an American Cancer Society state policy director who can serve as an important resource/advocate. Dr. Farleigh also recommended that Governors use the College as a resource to advance the issue, recognize the burden of colon cancer in their states and particular subpopulations, and identify cancer screening mandates already passed in the states.

7. **Medicare: Fee Schedule and SGR Fix**  
*Kevin Hayes, Ph.D.*

Kevin Hayes, Ph.D., Director, Physician Payment Issues, Medicare Payment Advisory Commission (MedPAC) explained that MedPAC has statutory authority to advise Congress on Medicare payment issues. He described concerns with rising Medicare Part B/physician spending and explained the options MedPAC has recommended to address the SGR.

8. **EMR in Your Practice**  
*James Leavitt, M.D., FACG*

James Leavitt, M.D., FACG reviewed his practice’s successful experience with implementing electronic medical records, the advantages of such systems, how to overcome likely challenges and things to consider in choosing among different possible systems.

9. **Propofol Sedation Issues**  
*Daniel J. Pambianco, M.D., FACG*

Daniel J. Pambianco, M.D., FACG discussed dissatisfaction with current sedation practices and described characteristics of the ideal agent and ideal delivery. He described future directions in sedation, including new drugs (fospropofol disodium), and new

Dr. Pambianco explained that fospropofol is safe and effective for moderate sedation and shows a high level of physician/patient satisfaction. Adverse events for the drug include groin paresthesia and hypoxemia. The FDA approved the drug as investigational in 2007.

Target controlled sedation is a pharmacokinetically based model and is computer-controlled. It automatically adjusts the rate of infusion to maintain the desired drug concentration or physiologic parameter. The open-loop system is set to deliver a target drug concentration while the closed-loop system uses feedback from a real-time measure of drug effect and desired level of sedation. A study of 20 colonoscopy patients (Campbell. Anesth 2004) compared propofol TCS with patient controlled handset to max 4.5 mcg/ml. Seven patients required MD override (3 to increase, 4 to decrease sedation). Another study of 40 colonoscopy patients (Stonell. Anesth 2006) compared propofol TCS with patient control to 0.8 mcg/ml vs. anesthesiologist-administered. Total dose was 238 vs. 288 mg. The patient controlled group was slowly and less deeply sedated. Patient satisfaction and recovery was comparable.

Computer-Assisted Personalized Sedation (CAPS) is a novel method integrating continuous physiological monitoring and delivery of propofol through a computer interface to provide precise control of sedation, enabling minimal to moderate sedation. Dr. Pambianco explained that the CAPS device facilitates titration to the desired clinical effect and responds to early signs of over-sedation (indicated by apnea/desaturation). At the point of over-sedation, the device stops propofol delivery, increases oxygen delivery, and instructs the patient to take a deep breath. When normal ventilatory function returns the device resumes the original infusion rate, resumes at a reduced infusion rate, or recommends a reduced rate, requiring a physician to resume. Studies of the CAPS system showed that propofol and fentanyl dosing was minimal in comparison to sedation by an anesthesia professional. In conclusion, Dr. Pambianco explained that study data was comparable across different practice settings and across different users. CAPS facilitated titration to the desired clinical effect: minimal/moderate levels of sedation, satisfied endoscopists, and satisfied patients. These results supported FDA approval of pivotal study and a multicenter trial is set to begin in 2007.

10. P4P / Measuring Quality in Your Office

David A. Johnson, M.D., FACG

After giving a historical background on the state of healthcare expenditures in the U.S., David A. Johnson, M.D., FACG began by asking the question, “Does the use of benchmarking equal quality?” He explained that the impact of implementing benchmarking may lead to adverse results. For example, a patient searches the Internet and finds that another physician has 0.05% better outcome than his/her physician, and consequently wants to change physicians.
Benchmarking changes physician behavior with financial incentives (quality bonuses, at
risk compensation pool, quality grants, variable cost sharing) and/or non-financial
incentives (publicizing performance, technical assistance, practice sanctions, reducing
administrative requirements). Dr. Johnson explained that 34% of physicians are affected
by practice profiling, 56% by guidelines, and 62% by patient satisfaction surveys (this
percentage should be higher).

Pay for Performance programs are incentive programs providing financial rewards to
physician groups and other entities, such as hospitals and health plans. The programs are
based on achievements using specific quality or efficiency benchmarks. Dr. Johnson
explained that the P4P model has achieved overwhelming support from employers,
payers, and industry, but has not yet been embraced by physicians. Analysis of P4P has
shown a positive effect on access but a negative effect on the sickest patient. In addition,
there is no definition of duration of effect and no cost effectiveness measures.

After detailing some examples of GI measure sets, Dr. Johnson stated that the key for
success is to “keep it simple” when developing P4P measure sets.

Dr. Johnson concluded with the following suggestions for success with P4P programs:

1. It is important to compile data on your practice now, which will likely require
   investment in technology. A good low-tech method is with patient
   satisfaction surveys.
2. Electronic medical records will help.
3. Benchmarking will be key (participation in performance-based programs)
4. Development of quality improvement plans
5. Recognize that you are already being benchmarked by insurers, peers, and
   patients.
6. Best data is by those who understand all implications and ramifications
7. Keep current with national society data.

11. Regional Caucus Meetings

Due to time constraints, Governors met to discuss issues in their regions, but did not
present them to the entire Board. Dr. Farraye requested that Governors e-mail him with
their reports.

12. CME Presentations

   a. New Treatment Options in IBD
      Kiran M. Das, M.D., FACG

   b. Management of Anticoagulants and Anti-Platelet Agents at the Time of
      Endoscopy
      David A. Greenwald, M.D., FACG
c. Barrett’s Esophagus Update
   *Richard E. Sampliner, M.D., MACG*

d. New Endoscopic Imaging Techniques (NBI, Confocal and OCT)
   *John R. Saltzman, M.D., FACG*

e. HBV/HCV Update
   *Stephen C. Hauser, M.D., FACG*

Meeting was adjourned at 3:30 p.m.