House of Delegates
Spring ‘13 Meeting

Baltimore, MD
March 2, 2013
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**Meeting:** House of Delegates Spring ‘13  
**Date:** March 1 – 2, 2013  
**Location:** Sheraton Inner Harbor  
300 S Charles St  
Baltimore MD 21201  
Tel: 410.962.8300 | Website: [http://www.sheraton.com/innerharbor](http://www.sheraton.com/innerharbor)  
**Staff:**  
Sandra B. Grear | Tel: 800-323-4040, x7536 | sgrear@cap.org  
Marci Zerante | Tel: 800-323-4040, x7656 | mzerant@cap.org

### Friday March 1, 2013

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
<th>Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome Reception</td>
<td>5 – 6:30pm</td>
<td>Chesapeake Gallery (3rd Level)</td>
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### Saturday March 2, 2013

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
<th>Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>HODRF Breakfast &amp; Registration</td>
<td>7 – 8am</td>
<td>Chesapeake Gallery (3rd Level)</td>
</tr>
<tr>
<td>HODRF Joint Session</td>
<td>8 – 9am</td>
<td>Chesapeake Ballroom (3rd Level)</td>
</tr>
<tr>
<td>HOD Meeting</td>
<td>9:10am – 11:55am</td>
<td>Harborview Ballroom (2nd Level)</td>
</tr>
<tr>
<td>HODRF Joint Lunch</td>
<td>Noon – 1:20pm</td>
<td>Chesapeake Ballroom (3rd Level)</td>
</tr>
<tr>
<td>HOD Meeting</td>
<td>1:30 – 4:30pm</td>
<td>Harborview Ballroom (2nd Level)</td>
</tr>
<tr>
<td>Networking Reception</td>
<td>4:30 – 6pm</td>
<td>Loch Raven Room (2nd Level)</td>
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Spring 2013
House of Delegates & Residents Forum
Joint Session
Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Duration</th>
<th>Topic</th>
<th>Presenter</th>
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</thead>
<tbody>
<tr>
<td>8:00 – 8:05am</td>
<td>5 mins</td>
<td>Welcome &amp; Introduction of CAP Officers, Governors and Guests</td>
<td>Roseann I. Wu, MD, MPH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>8:05 – 8:10am</td>
<td>5 mins</td>
<td>State of the Residents Forum</td>
<td>Roseann I. Wu, MD, MPH</td>
</tr>
<tr>
<td>8:10 – 8:15am</td>
<td>5 mins</td>
<td>State of the House</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>8:15 – 8:25am</td>
<td>10 mins</td>
<td>CAP Business Meeting</td>
<td>Stanley J. Robboy, MD, FCAP</td>
</tr>
<tr>
<td>8:25 – 8:40am</td>
<td>15 mins</td>
<td>Update from CAP President</td>
<td>Stanley J. Robboy, MD, FCAP</td>
</tr>
<tr>
<td>8:40 – 8:55am</td>
<td>15 mins</td>
<td>Update from CAP CEO</td>
<td>Charles Roussel</td>
</tr>
<tr>
<td>8:55 – 9:00am</td>
<td>5 mins</td>
<td>Closing Remarks</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>9:00 – 9:15am</td>
<td></td>
<td>Break, move into individual meetings</td>
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</tbody>
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# Spring 2013
## House of Delegates
### Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Duration</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:10 – 9:15am</td>
<td>5 mins</td>
<td>Welcome &amp; Overview</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>9:15 – 9:35am</td>
<td>20 mins</td>
<td>Strategic Overview: Vision, Voice and Value</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>9:35 – 9:45am</td>
<td>10 mins</td>
<td>Proposed Revisions to HOD Rules – Vote</td>
<td>Rodolfo Laucirica, MD, FCAP, V.O. Speights, DO, FCAP</td>
</tr>
<tr>
<td>9:45 – 10:30am</td>
<td>45 mins</td>
<td>CAP 2013 Candidate Forum: President-Elect Q&amp;A</td>
<td>Moderator: David A. Novis, MD, FCAP Candidate: Richard C. Friedberg, MD, PhD, FCAP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Timekeeper: Alfred W. Campbell, MD, FCAP</td>
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<tr>
<td>10:30 – 11:15am</td>
<td>45 mins</td>
<td>CAP 2013 Candidate Forum: Governor Q&amp;A</td>
<td>Moderator: James E. Richard, DO, FCAP Candidates: David L. Booker, MD, FCAP</td>
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<td></td>
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<td></td>
<td>Richard R. Gomez, MD, FCAP, Bharati Suketu Jhaveri, MD, FCAP, Emily E. Volk, MD, FCAP</td>
</tr>
<tr>
<td>11:15 – 11:45am</td>
<td>15 mins</td>
<td>Follow the Money: 2012 CAP Finance Update</td>
<td>Arthur H. McTighe, MD, FCAP, Speaker: Paul Valenstein, MD, FCAP</td>
</tr>
<tr>
<td>11:45 – 11:55am</td>
<td>10 mins</td>
<td>New Business</td>
<td>David A. Novis, MD, FCAP</td>
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**Noon - 1:20pm**

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<tr>
<th>Time</th>
<th>Duration</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
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<tbody>
<tr>
<td>1:20 – 1:30pm</td>
<td></td>
<td>Break and pass to HOD meeting</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>1:30 – 1:35</td>
<td>5 mins</td>
<td>Opening Remarks</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>1:35 – 1:55pm</td>
<td>20 mins</td>
<td>Part 1 – ACOs: What do we NOW know, What do we need to know, What do we not have a clue about?</td>
<td>Kathryn T. Knight, MD, FCAP, Speaker: Donald S. Karcher, MD, FCAP</td>
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<tr>
<td></td>
<td></td>
<td>a. Medicare ACO</td>
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<tr>
<td></td>
<td></td>
<td>b. Role of the Pathologist</td>
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<tr>
<td></td>
<td></td>
<td>c. ACO Network</td>
<td></td>
</tr>
<tr>
<td>2:50 – 3:05pm</td>
<td>10 mins</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>3:05 – 3:25pm</td>
<td>20 mins</td>
<td>Part 3 - Helping your Practice Address Emerging Health Care Payment Systems</td>
<td>John G. Newby, MD, FCAP, Speaker: Gene N. Herbek, MD, FCAP</td>
</tr>
<tr>
<td>3:25 – 4:15pm</td>
<td>50 mins</td>
<td>Part 4 - Your Opportunity to Help the College Help You NOW Roundtable Discussions</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>4:15 – 4:30pm</td>
<td>15 mins</td>
<td>Closing Remarks</td>
<td>David A. Novis, MD, FCAP</td>
</tr>
<tr>
<td>4:30 – 6:00pm</td>
<td></td>
<td>Networking Reception</td>
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*March 2, 2013 | Spring 2013 House of Delegates Meeting*
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Committee Minutes

BACKGROUND
The House of Delegates met on September 8, 2012 in San Diego, CA.

OBJECTIVES
• Approve draft minutes from House of Delegates meeting held September 8, 2012 in San Diego, CA.

CONTENTS OF THIS TAB
• September 8, 2012 Draft House of Delegates Minutes
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College of American Pathologists

MINUTES

COLLEGE OF AMERICAN PATHOLOGISTS HOUSE OF DELEGATES

September 8, 2012 San Diego CA

JOINT SESSION WITH RESIDENTS FORUM

WELCOME

Residents Forum Chair, Nicole D. Riddle, MD welcomed distinguished guests, CAP Leadership, House and Residents Forum members to the sixth annual House of Delegates/Residents Forum Joint Session at 8:03 am, Saturday, September 8, 2012, at the Manchester Grand Hyatt in San Diego CA.

INTRODUCTION OF CAP OFFICERS, GOVERNORS, AND OFFICIAL GUESTS

Dr. Riddle noted the presence in the audience of distinguished guests, State Pathology Society Presidents, current and past CAP officers and governors, as well as the Residents Forum Executive Committee and Residents Forum staff.
STATE OF THE RESIDENTS FORUM

Dr. Riddle, Residents Forum Chair, provided an update of the state of the Residents Forum. She explained representation for Residents Forum; nine Residents Forum Executive Committee members and RF delegates from each US and Canadian program. Dr. Riddle reported that Residents Forum membership is up from last year and both Spring and Fall meeting registration is also doing well. Key items that will take place during the their session will include: election of a new Residents Forum Executive Committee, short discussions on ACGME Milestones, ABP Exam, and CAP GMEC Job Market, small group breakout sessions on Best Practices for Duty Hours/PGY1 Schedules and Graduated Responsibilities and an afternoon panel discussion on What Residents Want to Know In Order to Choose a Practice Setting Right for Them.

WELCOME

House Speaker, David A. Novis, MD, FCAP welcomed House and Residents Forum members and introduced the House of Delegates Steering Committee members and staff.

STATE OF THE HOUSE

Dr. Novis explained that the role of the House in our One College mantra is to be the Voice of the Membership. The way the House articulates that voice is to Be the Customer and apprise the College of how delegates feel the College is doing...
at meeting the needs of its members.

In the last year the House had five Action Groups (AGs) designed to build infrastructure that will allow us to operate as the customer. Three of these AGs were involved in member engagement: get residents and new-in-practice members more involved in the House, get State Society Presidents more involved in the House and get the Delegate Chairs more involved in leadership of the House. A fourth AG is working on building conduits of information about what the College is doing to meet the needs of its members. The last AG, Leadership, is designed to get delegates more involved in leadership positions throughout the College making the House the gateway to leadership within the College.

Dr. Novis explained that the House operates in the here and now by processing delegate issues three ways: online dialog between delegates and Governors where delegates articulate their needs and Governors respond with how the College is meeting those needs, candidate forum at the Spring meeting designed to allow delegates to ask officer and governor candidates how they plan to meet the needs of the members and report cards which apprise the College of how well they are meeting the needs of the members.

Dr. Novis reviewed the latest House report cards which are the metrics that report how well we are doing. By all measures things are moving in the right direction; meeting registration is at an all time high, membership continues to grow and satisfaction is improving.

On a final note, Dr. Novis shared that today’s House agenda includes the House
of Delegates Steering Committee elections. If delegates elect those on the slate, the strategy for the next two years is even more aggressive and exciting.

For the full details of this speech please visit the [HOD Topic Center](#). Audio files and PowerPoint files from the Fall ’12 HODRF Joint Session are available on the [See & Listen](#) page.

**CAP BUSINESS MEETING**

CAP President Stanley J. Robboy, MD, FCAP conducted the CAP Business meeting which included approval of meeting minutes, awards, election results and installation ceremonies and acknowledgement of outgoing board members.

For the full details of this speech please visit the [HOD Topic Center](#). Audio files and PowerPoint files from the Fall ’12 HODRF Joint Session are available on the [See & Listen](#) page.

**UPDATE FROM THE CAP PRESIDENT**

CAP President, Stanley J. Robboy, MD, FCAP, opened his speech by offering his respect to this group’s collective wisdom and stating that he is pleased to see the dynamic partnership that has grown in recent years between the Board and the House. Delegate words are heard and their voices help shape Board actions.

In his speech, Dr. Robboy addressed issues of importance to delegates and highlighted many CAP tools and resources available to members. He explained that Genomics covers a wide range of new areas with new technologies that...
pathologists must master in order to excel in the future. He also explained how an Accountable Care Organization (ACO) environment will enable pathologists to return to the traditional position of clinician physician and function again much as pathologists did before the current payment model.

For the full details of this speech please visit the HOD Topic Center. Audio files and PowerPoint files from the Fall ’12 HODRF Joint Session are available on the See & Listen page.

**Update from the Chief Executive Officer**

Chief Executive Officer of the College, Charles Roussel, provided an update on the College’s now and future agendas that support the specialty and CAP members by highlighting data from the completed eighteen month Case for Change. Mr. Roussel stated that the bottom line is that we are going to be okay and we have reason to be optimistic. He described the Case for Change findings by way of two tectonic plates in motion; one fueled by genomics and informatics and the other economic; fueled by healthcare reform and coordinated care. He explained that at the convergence of these shifts is sustainable advantage for pathology. That advantage comes from analyzing data and understanding disease at the molecular level. In his speech, he described these two things as being the keys to unlocking value in tomorrow’s healthcare and stated that pathology can drive value in ways that very few other specialties can.

For the full details of this speech please visit the HOD Topic Center. Audio files
and PowerPoint files from the Fall ’12 HODRF Joint Session are available on the See & Listen page.

CAP FOUNDATION LEADERSHIP AWARDS

Jennifer L Hunt, MD, MEd, FCAP, President CAP Foundation bestowed the CAP Foundation Leadership Awards.

HOUSE OF DELEGATES SESSION

CALL TO ORDER

Speaker of the House, David A. Novis, MD, FCAP, called to order the regular session of the College of American Pathologists House of Delegates at 9:40 AM, Saturday, September 8, 2012.

APPROVAL OF THE SPRING 2012 MINUTES

It was moved, seconded, and CARRIED to APPROVE the minutes of the March 17, 2012 House of Delegates meeting in Vancouver, BC.

HOD STRATEGIC OVERVIEW AND AGENDA

Dr. Novis welcomed delegates/alternates and guests to the best registered HOD meeting in CAP History. He began his speech with a review the HOD strategic plan and agenda. The story starts with a survey that we sent out two years, the results of which showed the College and the House had drifted too far apart. For College of American Pathologists
the House this meant membership was low, attendance was low and moral was low. Our One College mantra, is based on all facets of the College working toward a common goal. The role of the House is to be The Voice of the Membership and the way to articulate that voice is to Be the Customer. Dr. Novis provided some history on the original design of the House as a legislator and why this didn’t work.

For the full details of this speech please visit the HOD Topic Center. Audio files and PowerPoint files from the Fall ’12 HOD meeting are available on the See & Listen page.

**HODSC ELECTIONS: READING OF THE SLATE, CALL FOR FLOOR NOMINATIONS AND CANDIDATE SPEECHES**

House Vice-Speaker, Rebecca L. Johnson, MD, FCAP lead the HODSC elections during the HOD meeting. Chair of the 2012 Nominating Committee, John Harbour, MD, FCAP recognized the members of the 2012 Nominating Committee, discussed the process used to determine the slate and read the slate. David Gang, MD, FCAP Massachusetts Delegate nominated Michael Misialek, MD, FCAP, Massachusetts Delegation Chair from the floor for the office of Sergeants-At-Arms.

Candidate speeches were heard from Dr. Novis, running for Speaker and all those running for Sergeants-At-Arms: Alfred Wray Campbell, MD, FCAP, Michael Misialek, MD, FCAP and John G. Newby, MD, FCAP.

*College of American Pathologists*
In Dr. Novis’ speech, he outlined the strategy for achieving One College and the course of action the Steering Committee (SC) Slate will take over the next two years, if elected. He described how the activities of the SC over the past two years have been successful in achieving their goal of getting the House to embrace the College. The next two years will focus on part two of that strategy which is to get the College to embrace the House. It is this partnership that will achieve One College. To accomplish this, the SC plans to have House Action Groups work with College Councils and Committees to devise ways in which Delegates participate in their activities.

The following candidates running unopposed were elected by acclimation:

Speaker:    David A. Novis, MD, FCAP
Vice-Speaker:  James E. Richard, DO, FCAP
Secretary/Treasurer: Arthur H. McTighe, MD, FCAP
Member-At-Large:  Kathryn T. Knight, MD, FCAP and Rodolfo Laucirica, MD, FCAP

Those running for Sergeants-At-Arms were elected by paper ballot. The 2012 Elections Oversight Committee: Cynthia Foss-Bowman, MD, FCAP; Laura Gardner, MD, FCAP, Fred Rodriguez, MD, FCAP and Mark Synovec, MD, FCAP assisted Dr. Johnson with the collection and counting of ballots for the office of Sergeants-At-Arms. The following members were elected to the office of Sergeants-At-Arms:

Alfred W. Campbell, MD, FCAP
John G. Newby, MD, FCAP
For the full details of candidate speeches visit the **HOD Topic Center**. Audio files and PowerPoint files from the Fall ’12 HOD meeting are available on the [See & Listen](#) page.

**SPECIAL RECOGNITION OF HOD MEMBERS**

House Speaker, David A. Novis, MD, FCAP, recognized long standing HOD delegate Richard Boatsman, MD, FCAP for his service to the HOD. Dr. Novis presented an award to outgoing Vice-Speaker, Rebecca L. Johnson, MD, FCAP in recognition of her dedication and service to the House of Delegates.

**SUSPENSION OF PARLIAMENTARY PROCEDURE**

It was moved, seconded, and CARRIED to SUSPEND parliamentary procedure.

**AG UPDATES**

Dr. Novis provided an update on the five AGs from the past year; highlighting three of the five have completed their charge. The remaining two AGs will conclude their work in 2013. New AGs will be formed in 2013. Interested delegates/alternates should contact HOD Staff Marci Zerante.

For the full details of this update please visit the **HOD Topic Center**. Audio files and PowerPoint files from the Fall ’12 HOD meeting are available on the [See & Listen](#) page.
CAP ANSWERS TO DELEGATE QUESTIONS: ADVOCACY UPDATES

Chair, Council on Government and Professional Affairs, Richard C. Friedberg, MD, PhD, FCAP provided delegates an update on health care reform, CAP Key Issues and the CAP 2013 Policy Meeting.

For the full details of this update please visit the HOD Topic Center. Audio files and PowerPoint files from the Fall ’12 HOD meeting are available on the See & Listen page.

NEW BUSINESS

Dr. Novis asked if there is any new business to come before the House. No new business was brought from the floor.

PART II: WHAT’S IN IT FOR PATHOLOGISTS: GENOMICS AND ACOs

Dr. Novis opened the panel by explaining that in the latest survey results HOD members ranked Genomics and ACOs as top issues of importance. The afternoon panels were designed to help members prepare for these issues.

During the first panel, members will hear about the business case; why it’s important to be involved in Genomics and ACOs and how pathologists will derive income for these services. He reminded the audience that both panels are being video and audio recorded. Panelists for this segment included: Debra G. B. Leonard, MD, PhD, FCAP, Mark Synovec, MD, FCAP and Donald S. Karcher, MD, FCAP. A Q&A segment followed the panel discussion.
For the full details of this panel please visit the HOD Topic Center. Audio files and PowerPoint files from the Fall ’12 HOD meeting are available on the See & Listen page.

**PART II: HOW THE CAP IS HELPING YOU MAKE IT WORK IN YOUR PRACTICE**

Dr Novis stated that as Part II, this panel is designed to help members understand what the College is doing to help you prepare for new pathology practice paradigms.

CAP CEO, Charles Roussel, delivered opening remarks highlighting CAP efforts and data from the Case for Change study with G2 Intelligence.

Andrew Horvath, MD, FCAP also delivered opening remarks highlighting data from the Case for Change study.

Panelists for this segment included: Michael Prystowsky, MD, PhD, FCAP, Michael Laposata, MD, PhD, FCAP and Eleanor Herriman, MD, MBA. A Q&A segment followed the panel discussion.

For the full details of this panel discussion please visit the HOD Topic Center. Audio files and PowerPoint files from the Fall ’12 HOD meeting are available on the See & Listen page.

**WRAP-UP AND ANNOUNCEMENTS**

Dr. Novis thanked all members for their attendance and reminded delegates/alternates of their responsibilities to communicate, serve and attend.
Delegates/Alternates are asked to complete all surveys so we know how we are doing, check the website and post your comments, communicate your issues to your Delegate Chair so we can bring them to the College for you, share the information you learned today with your constituents and attend the next meetings: Spring 2013 HOD Meeting in March, the CAP Policy Meeting in May 2013 and the Fall 2013 HOD Meeting in October.

For the full details of this wrap-up please visit the HOD Topic Center. Audio files and PowerPoint files from the Fall ’12 HOD meeting are available on the See & Listen page.

**ADJOURNMENT**

Meeting adjourned at 4:05pm on September 8, 2012.
BACKGROUND:
In 2011 the HOD instituted Action Groups (AGs) to build a new infrastructure and communicate delegate issues.

The following Action Groups have submitted final reports for the Spring ’13 HOD meeting and will be sunsetting following this meeting:
- HOD AG on Leadership II

The following Action Groups are have submitted reports and will continue their work until the Fall ’13 HOD meeting:
- HOD AG on Rules II
- HOD AG on Council on Government and Professional Affairs
- HOD AG on Council on Membership and Professional Development

The following Networking Action Groups will launch after the Spring ’13 meeting:
- HOD AG on Council on Education
- HOD AG on Council on Scientific Affairs
- HOD AG on Council on Accreditation

All reports found in this agenda book are also available on the HOD Website.

www.cap.org/hod

CONTENTS OF THIS SECTION
- Report A – Report of the HOD AG on Leadership II
- Report B – Report of the HOD AG on Rules II
- Report D – Report of the HOD AG on Council on Membership and Professional Development
- Report E – Report from the CAP Secretary/Treasurer
- Report F – Report from the Council on Accreditation
- Report I – Report from the Council on Membership and Professional Development
- Report K – Report from the Transformation Program Steering Committee
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Report A

Topic: House of Delegates Leadership II Action Group

From: David L. Gang, MD, FCAP
Leadership II Action Group, Chair
Kathryn T. Knight, MD, FCAP
Leadership II Action Group, HODSC Liaison

Date: February 11th, 2013

1. PURPOSE OF THIS REPORT

Information – provide a final status update on work being done by the Action Group.

The charge of this AG is:
To develop a plan, i.e. resource guide, to assist members of the CAP House of Delegates in locating and obtaining leadership opportunities within the HOD and CAP.
To develop performance metrics, i.e. a report card, to evaluate the success of HOD members on the leadership ladder.

Brainstorming or input requested of the HODSC:
   a. None.

Decisions requested of the HODSC:
   a. None.

Approvals requested of the HODSC:
   a. Approval of Resource Guide.
   b. Approval of Proposed Metrics for HOD Delegate Performance Report Card.
   c. Approval of Recommendations for Next Steps.

2. CURRENT STATUS

   - Three new members were added to the group at the CAP '12 HOD meeting in San Diego: Lelani Valdes, MD, FCAP; Christopher Bee, MD, FCAP and Matthew Carr, MD, FCAP
   - Original groups members are: Elizabeth Hammond, MD, FCAP; Mary Fowkes, MD, FCAP; Shelby Melton, MD, FCAP; and John Cangelosi, MD, FCAP; in addition to Drs. Gang and Knight.
   - A conference call took place on 10/24/12 with a discussion of the major elements to be included in the resource guide.
   - Due to a problem with conflicting schedules and illness, the conference call for November 15th was cancelled; Drs. Gang and Knight instead worked on the draft of the resource guide.
   - Drafts of the resource guide and report card elements were provided to committee members via e-mail on 12/2/12 and a final phone conference call was held on 12/13/12.
   - Members shared comments and accepted the final versions of the resource guide and metrics of performance via e-mails in December, 2012.
   - A decision was made to submit the final report for the HOD meeting in Baltimore for 3/2/13.
Resource Guide: Activities to Assist HOD Members in Seeking Leadership Opportunities within the HOD and the CAP

1. Networking: Attend the twice yearly HOD meetings
   • Take advantage of opportunities to network with fellow delegates, members of HOD Steering Committee, and CAP officers, and introduce yourself to members of CAP staff
   • Attend network receptions at meetings (bring business cards)
   • Ask members of Steering Committee about serving on HOD Action Groups
   • Meet and interact with home State Delegate Chair and fellow delegates
   • Seek out delegates currently serving on CAP Committees and Councils for advice/mentoring on pathways to securing an appointment (list is available on HOD web site and updated yearly in Spring Meeting Agenda Book)

2. Advocacy: National, State, and Local
   • Attend the annual CAP Washington Policy Meeting
   • Become familiar with key CAP Legislative Issues
   • Meet and network with CAP Leadership and Washington Office Staff
   • Meet and discuss key issues with your Congressman and Senators through Hill Visits Program
   • Master key issues and discussion points to share with fellow pathologists in home state
   • Meet and discuss key issues with your state legislators in State Capital or local offices
   • Sign up for PathNET – Be willing to go to Washington or contact your legislators on important issues/legislation impacting Pathology
   • Host a lab tour – Invite your congressional representative to tour your hospital laboratory
   • Support and become active in local patient advocacy groups such as: American Cancer Society; Susan G. Komen For the Cure; Crohn’s and Colitis Foundation; local cancer support groups; and men’s and women’s health advocacy groups

3. Communication: Become a Spokesperson for your profession
   • Seek the opportunity to participate in Engaged Leadership Academy (ELA) through an invitation from the CAP Division of Membership – this program was formerly known as Spokesperson’s Training Program (STP)
   • Targeted invitees are selected as active proponents of pathology to augment and further develop identified leadership potential and communication skills.
   • ELA sessions are designed to focus on local engagement activities that promote the profession and the adoption of transformation practices, including utilization of brief encounters to facilitate further discussions.
   • Past attendees (STP) and ELA attendees have improved their communication skills through presentations with feedback from colleagues, learned to advocate more clearly and effectively for CAP issues, and gained invaluable experience with recorded/videotaped interviews for potential chance or scheduled encounter with administration and media.
   • As graduate of ELA, join the CAP Engaged Leadership Network to increase the profession’s visibility and improve the pathologist’s image by developing relationships with patients, community leaders, patient advocacy groups, and within the hospital with clinicians and others whom pathologists must influence.

4. Professional Engagement: Be active on State and Local level
   • Join state pathology society
College of American Pathologists

- Attend state society meetings
- Become member of state society executive committee
- Share knowledge of key issues from CAP HOD with state society
- Join city/county/state medical society
- Take leadership role on hospital medical staff
- Meet with state legislators on behalf of CAP/laboratory issues
- Participate in CAP lab inspections (maintain inspector eligibility)
- Create dialogue, provide a picture of high performance, and create processes that strategically engage people’s attention

**Proposed Metrics for Leadership AG II: HOD Delegate Performance Report Card - Objective**

1. Attendance at HOD meetings – 1 per year, 2 per year
2. Participation in State Delegation
   a. Serves as Chair of State Delegation
3. Participation in HOD Action Groups
   a. Consistently takes part in phone conferences
   b. Follows through on assignments
   c. Serves as chair of Action Group
4. Attendance at the CAP annual meeting
5. Attendance at the annual CAP Washington Policy Meeting
6. Attendance (by invitation) at Engaged Leadership Academy (formerly Spokesperson’s Training)
   a. Participation in Spokesperson’s Network
7. Participation in Grass Roots Advocacy - PathNET Program/Hill Visits
8. Hosting a hospital laboratory tour for Congressman or Senator
9. Sponsoring a hospital See, Test, and Treat program
10. Participation in CAP Peer2Peer Program
11. Participation in CAP Lab Inspections
    a. Team Leader for Lab Inspection
12. Membership/Officer in State Pathology Society
13. Membership/Officer in State Medical Society
14. Membership/Officer in Local City/County Medical Society
15. Leadership Role in Hospital/Health System/Group Practice Board
16. Leadership role in local/regional PHO and/or ACO
17. Appointment to CAP Committee/Council

**Proposed Metrics for Leadership AG II: HOD Delegate Performance Report Card - Subjective**

1. Communication
   - Makes clear and convincing presentations to individuals or groups.
   - Facilitates an open exchange of ideas and fosters an atmosphere of open communication.
   - Expresses facts and ideas in writing in a clear, convincing, and organized manner.
2. Interpersonal Skills
   - Considers and responds appropriately to the needs, feelings, and capabilities of different people in different situations.
3. Influencing/Negotiating
   - Gains cooperation from others to obtain information and accomplish goals.
4. Continual Learning
   - Pursues self-development
   - Seeks feedback from others and opportunities to master new knowledge.
5. Flexibility
   • Adapts behavior and work methods in response to new information, changing conditions, or unexpected obstacles.

6. Integrity/Honesty
   • Behaves in an honest, fair, and ethical manner toward others.
   • Demonstrates a sense of corporate responsibility and commitment to patient care.

7. Team Building
   • Encourages and facilitates cooperation within the organization and with customer groups.
   • Develops leadership in others through coaching, mentoring, rewarding and guiding.

8. Problem Solving
   • Distinguishes between relevant and irrelevant information to make logical decisions.
   • Provides solutions to individual and organizational problems and makes recommendations.

9. Accountability
   • Can be relied upon to ensure that projects within areas of specific responsibility are completed in a timely manner.

10. Decisiveness
    • Exercises good judgment by making sound and well-informed decisions.

11. Conflict Management
    • Encourages and accepts differences of opinions.
    • Anticipates and takes steps to prevent counter-productive confrontations.
    • Manages and resolves conflicts and disagreements in a positive and constructive manner to minimize negative impact.

12. Creativity and Innovation
    • Creates a work environment that encourages creative thinking and innovation.

13. Partnering
    • Collaborates across boundaries to build strategic relationships, and finds common ground with a widening range of stakeholders.

14. External Awareness
    • Understands, identifies, and keeps up-to-date on local, key national and international policies and trends that affect the organization and shape stakeholders’ views, economic, political, and social trends that affect the organization.
    • Aware of the organization’s impact on the external environment;
    • Understands near-term and long-range plans and determines how best to be positioned to achieve organizational success and provide quality patient care.

15. Strategic Thinking
    • Formulates objectives and priorities, and implements plans consistent with the long-term interest of the organization.

3. **NEXT STEPS: RECOMMENDATIONS** - Development of online resources to support HOD members
   • Maintain list on HOD web site of delegates currently serving on committees and councils.
   • Create HOD meeting badge marker to identify members currently serving on committees and councils.
   • Post selected case histories/testimonials from successful delegates serving on committees and councils with practical advice for house members seeking these positions (to begin with postings by current members of Leadership AG II).
   • Identify site on HOD or CAP web site for members to record accomplishments and activities for use by Steering Committee and Board of Governors in helping to select candidates for appointment to CAP committees and councils.
Report B

Topic: AG on Rules II

From: V.O. Speights, DO, FCAP
AG on Rules II, Chair
Rodolfo Laucirica, MD, FCAP
AG on Rules II, HODSC Liaison

Date: February 8, 2013

1. PURPOSE OF THIS REPORT

   Information – provide a status update on work being done by the Action Group.

   Brainstorming or input requested of the HODSC:
   a.

   Decisions requested of the HODSC:
   a.

   Approvals requested of the HODSC:
   a. Review of this report
   c. Approach to increasing military membership in the House (work of a new AG)

2. CURRENT STATUS

   • Accumulation of issues to discuss, appropriate surveys and conference calls
   • Past and Present CAP high officers serving in the House, State Society Presidents as ex officio Members of the House, Immediate Past Speaker serving as advisor to HODSC—see proposed amendments
   
   Other issues:
   1. Nominations from the floor at the fall meeting
      a. HOD members surveyed, 84% in favor of having the opportunity to nominate additional candidates from the floor.
      b. AG recommendation: Leave Rules Article IV, section 1.c as is
   2. Increase participation in HOD by military pathologists
      a. Gathered input from pathologists with military background (Barbara Crothers, D.O., Aaron Auerbach, M.D.)
      b. Gathered input from AMA about participation in their House by military members (Susan Strate, M. D.)
      c. Work with Council on Membership and Professional Development
      d. This item is a work in progress.
      e. AG Recommendation: pass all information collected to the next AG on Rules
   3. Electronic attendance of HOD meetings
a. AG recommendation: current need is to continue with the momentum of face to face meetings
b. Consider as a topic for the future.

3. **NEXT STEPS**
   - Continue work on increasing military membership through summer and provide final report from this AG at the Fall 2013 House meeting.
   - Currently there is a delegate and alternate from each branch of service—Army, Air Force, Navy
   - Do we increase the number of delegate positions for the military?
   - Do we encourage military pathologists to serve as delegates from the states they live in?
   - Suggest a new AG be formed to continue work on this issue, which is getting into areas not in the current AG charge of HOD rules.
Proposed Amendments to Rules of the House of Delegates
February 2013

<table>
<thead>
<tr>
<th>Original Bylaw</th>
<th>Revised Bylaw</th>
<th>Rationale for change</th>
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<tbody>
<tr>
<td>Article V, Section 6--officers of the College, members of the Board of Governors and past Presidents of the College shall have all privileges of the House but may not hold office, vote or serve on committees.</td>
<td>Current and past officers of the College and members of the Board of Governors shall have all privileges of the House but may not serve as delegates, vote, hold office, or serve on House committees.</td>
<td>The intent of this Rule is to allow input from current and past CAP officers and Governors, but offer leadership opportunities only to Delegates who have not yet had those opportunities. An HOD survey showed that 67% of Delegates supported this bylaw revision.</td>
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<tr>
<td>Article 2, Section 4 (b) line 6--State Pathology Society Presidents may serve as ex officio members of their state society delegation if not already a member of the delegation.</td>
<td>State Pathology Society Presidents who are CAP Fellows may serve as ex officio members of their state House Delegations.</td>
<td>This revision expands the sphere of the House of Delegates to include State Pathology Societies.</td>
</tr>
<tr>
<td>Article III, Section 5 (d)--a new addition</td>
<td>The immediate Past Speaker of the House shall serve on the HOD Steering Committee as an Advisor for one term immediately following his/her term as Speaker.</td>
<td>This revision provides continuity between outgoing and incoming Steering Committees.</td>
</tr>
</tbody>
</table>
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1. PURPOSE OF THIS REPORT
   Information – The AG on CGPA is close to starting its mission following initial interactions with the CGPA.

   Brainstorming or input requested of the HODSC:
   a. None.

   Decisions requested of the HODSC:
   a. None.

   Approvals requested of the HODSC:
   a. None.

2. CURRENT STATUS
   1. Charge and deliverables defined:
      Charge: Ask the Councils and Committees, “What can the HOD do to help advance whatever work you are doing?”
      Deliverable: The answers to that question in a form that we can turn into definable projects.

   2. Following discussions between HOD and CGPA leadership a decision was made to limit networking directly to Drs. Friedberg (CGPA Chair) and Craver. The entire AG will then mobilize the collected project ideas and that will be the new focus of achievement for the AG.

3. NEXT STEPS
   a. Dr. Craver to initiate networking with Dr. Friedberg.
   b. Entire AG actions are on hold pending outcome of 3.a.
   c. AG conference call update scheduled for 2/6/13 at 3 PM CT.
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Report D

Topic: AG on the Council of Membership and Professional Development

From: Michael J. Misialek, MD, FCAP
AG on the Council of Membership and Professional Development, Chair
Arthur H. McTighe, MD, FCAP
AG on the Council of Membership and Professional Development, HODSC Liaison

Date: February 12, 2013

1. PURPOSE OF THIS REPORT

   Information – provide a status update on work being done by the Action Group.
   AG Members include:
   Michael Misialek, MD, Arthur McTighe, MD, Wayne Garrett, MD, Karla Murphy MD, Gerald Wedemeyer, MD, Amanda Wehler, MD

   Brainstorming or input requested of the HODSC: None
   Decisions requested of the HODSC: None
   Approvals requested of the HODSC: None

2. CURRENT STATUS – CONFERENCE CALLS WERE HELD 11/27/12, 1/16/13

   1. The CAP Council/Committee org chart was discussed.
   2. We reviewed and explained the charge of the AG.

   The purpose of the Action Group is to network with the Council on Membership and Professional Development.

   a) Know the members serving on the Council/Committee
   b) Better understand the purpose, mission and goals of the Council/Committee
   c) Determine how/if the HOD can help them advance their mission/goals

3. Distribution of Duties

<table>
<thead>
<tr>
<th>Member</th>
<th>Committee/Council</th>
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<tbody>
<tr>
<td>MM</td>
<td>Council on Membership and Prof. Dev.</td>
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<tr>
<td>AM</td>
<td>New in Practice Committee</td>
</tr>
<tr>
<td>WG</td>
<td>Practice Management Committee</td>
</tr>
<tr>
<td>KM</td>
<td>Member Engagement Committee</td>
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<tr>
<td>GW</td>
<td>Committee on Prof &amp; Comm Engagement</td>
</tr>
<tr>
<td>AW</td>
<td>Residents Forum Exec Committee</td>
</tr>
</tbody>
</table>

3. NEXT STEPS

   A new operational plan was discussed and will look like this:
1. AG Chair will network with the Council Chair to ask the question “How can the HOD help you advance your goals/agenda?”
2. The AG Chair will report back to the AG team members any and all findings (we hope this will be a list of projects)
3. The AG members will then work with HOD Staff to operationalize said projects.

The idea behind this new plan of keeping networking to just the two leaders (AG Chair and Council Chair), is to retain confidentiality of Council information, maintain integrity of interpretation of information shared and create greater opportunity for AG member engagement.
The following is a recap of financial results of the College for the fiscal years ended December 31, 2012 and 2011. Please note that the 2012 results, as presented, are unaudited. We do not anticipate any adjustments to these preliminary results, but they are subject to change based on the results of our annual audit.

**Revenue**

Revenue for 2012 of $161.9 million increased by $7.7 million, or 5.0%, over the prior year. The College had strong revenue increases in the Proficiency Testing (PT) and Laboratory Accreditation Program (LAP) product offerings, but had lower revenues from the STS product offerings than the prior year. Overall, the College fared very well in a tough economy.

**Cost of Materials and Onsite Inspection**

Cost of materials and onsite inspections for the year increased by $4.3 million in 2012 versus 2011. Cost of materials related to PT increased over the prior year as a direct function of the increase in revenue, while the cost of onsite inspections for LAP rose slightly over the prior year, a concerted effort is made to control travel costs. As a percentage of revenue, cost of sales of 34.2% in 2012 increased from the prior year actual of 33.1%, with the majority of the increase coming from Proficiency Testing materials and packaging costs.

**Operating Expenses**

Total CAP Expenses of $186.0 million for the 2012 year equaled the 2011 year. CAP continues the long-term investment in the College and the membership. Major projects include our spending on the Transformation Program Office (TPO), Enterprise Platform Program (EPP), International expansion, and Communications.

High spending occurred in the areas of outside consulting and personnel and benefits expense. The increase in the personnel and benefits was in line with the budget. Outside consulting was reduced from the prior year as the College redefined the EPP project.

Excess Revenue Over Expenses from operations showed an increase over the budget. The long-term investment portfolio decrease slightly which was in line with the overall market performance and was better than anticipated due to decrease spending on EPP. Overall, the financial performance for the year was good.
As in prior years, audited financial statements will be presented to the Finance Committee at their March meeting and at the May Board meeting. The House of Delegates will receive the audited financial statements at the annual meeting.
1. INTERNATIONAL BUSINESS OPERATIONS

In 2011, the International Operations Planning Group launched a set of targeted project/work teams to ensure tight coordination of effort in support of expansion goals. The work teams include: CAP Global, International Inspector Certification Program (IICP), Translation Services, and Customer Support—Issue Resolution and Planning. To date, the CAP Global and IICP teams have achieved the goals and objectives outlined in the charter and have closed out their projects. The Translation Services team will continue efforts to translate the Accreditation Checklists and operationalize the process for ongoing quality review and maintenance. The Customer Support work team will continue to meet on a monthly basis with a focus on customer service, issue resolution, and operational improvement. Other priorities have included:

a. **CAP Implementation of the Foreign Corrupt Practices Act (FCPA) Policy:** CAP staff reviewed the revised policy with the Commission on Laboratory Accreditation (CLA) during the CLA’s October meeting and received approval pending some additional revision. The revised policy will appear on the back of the Inspector Summation Report and serve as the primary attestation mechanism. Education staff collaborated with the Accreditation Education Committee and the Inspection Process Committee to develop new FCPA scenarios for incorporation into online inspector training. The scenarios will be available in the online training in December 2012.

b. **Laboratory Director Acceptance Criteria:** Accreditation staff recently engaged an outside service to conduct an equivalency review of a subset of international director qualifications (CVs) as input to the criteria CAP will use to determine acceptance. CAP received initial results at the end of September and presented to the CLA in October. During the CLA discussion, the approved change to Standard I (Director and Personnel) to exclude the word “doctoral” before the phrase “qualified scientist” was revisited. The CLA put forth an action item to reconsider the change to the Standard and offered alternative language for consideration by the Council on Accreditation and the Executive Committee to the Board. Accreditation staff will continue working on the
proposal to implement a more robust process to manage review of laboratory director changes for existing accredited laboratories and for initial review and acceptance of international laboratory directors.

c. **International Inspector Certification Program (IICP):** During the CLA meeting, CAP staff and members discussed future plans for the IICP and lessons learned from the initial round of training and certification activities. In China and India, conflict of interest issues continue to make it challenging to use IICP participants on more inspections. Participation on an observation inspection is currently a required component for certification. Additionally, it will be important to ensure diversity in trainee discipline expertise to allow for greater use of the IICP inspectors on in-country inspection teams. Discussion is in progress with Executive staff and members regarding 2013 plans for training sessions.

2. **BIOREPOSITORY ACCREDITATION PROGRAM (BAP)**
   The CAP kicked off inspections of biorepositories in early May. We have accredited seven sites and completed 14 inspections. The operations team plans to complete a total of 19 inspections this year, and more may be planned contingent upon biorepository readiness and inspector availability. Some of the most recent applications to the program have been received from Cleveland Clinic, Quest, Duke, and Johns Hopkins. Currently, there are 31 sites in the program. Our goal is to reach 32 by year’s end. The BAP Advisory Working Group meets bi-weekly via conference calls and plans to meet again face-to-face in the fall as we continue to refine the checklist and off-year processes. The next inspector training will be in the fall of 2012 in Maryland – by invite only.

3. **SOFTTECH HEALTH/CAP PARTNERSHIP**
   There are currently more than 200 potential leads for the CAP Accreditation Manager, new software that automates customized checklists. The sales cycle is anticipated at 12-18 months based on SoftTech Health sales history. However since the deployment on March 31, 2012, there have been two completed sales at approximately seven months. Accreditation, Marketing, and Communications staff have revisited and clarified the value proposition and results of the work will begin to appear in the next wave of advertising.

4. **CAP 15189**
   Currently, the CAP has 40 laboratories enrolled in CAP 15189 and more than 70 prospects. For year-to-date-revenue of CAP 15189 accreditation and education, we stand at $325,027 (budget $355,592). There are 19 CAP 15189-accredited laboratories. The newest include LabCorp Denver and Driscoll Children’s Hospital. In addition, we have launched Continuing Education credit for the CAP’s QMed seven educational courses to support CAP customers in building quality as a strategic business initiative.
5. CAP ACREDITATION READINESS ASSESSMENT (CARA®)

The new CARA offering continues to move ahead successfully in 2012. A total of 15 CARAs have been completed and two are scheduled to complete prior to year end. These 17 CARAs encompass a total of 28 laboratories. Three of the 2012 CARAs are international laboratories. Participant laboratories include full-service hospital-based laboratories, specialty laboratories, and dermatopathology or urology clinics. We anticipate CARA assessments will generate approximately $70,000 in new revenue for CAP in 2012. (Exceeding the target of $60,000)

**Note:** The CARA provides a high-level evaluation of the laboratory’s processes using an educational approach. Focusing on a review of 10 areas of key laboratory operations and documentation, the CARA will not only assess inspection readiness, but also help the laboratory’s personnel understand what to expect from an inspection team.

6. 2012 CHECKLIST EDITIONS

2012 brought three new accreditation checklist editions. The content additions have evolved with the ever-changing environment keeping laboratories current with the latest technologies and quality practices.

- **January**
  - The January 6, 2012 edition featured:
    - The first-ever biorepository accreditation checklist. This is used for biorepositories storing specimens for non-transplant related research. This checklist only applies to biorepositories that are enrolled in the CAP’s new Biorepository Accreditation Program.

- **July**
  - The July checklists feature many enhancements including:
    - A revised version of the Molecular Pathology Checklist with a dedicated section on Next Generation Sequencing (NGS). The CAP is the first to publish an accreditation checklist that addresses NGS, advancing standardized practice in genomic testing.
    - More examples of acceptable documentation for efficient preparation and inspection.
    - References to outside agencies generalized for clarity.
    - More about the CAP Accreditation Manager™, new software from CAP that automates your customized checklists and takes the pain out of updating your laboratory’s documents to reflect the latest checklist revisions.
    - Customization to exclude U.S.-only requirements for international non-CLIA laboratories. This new change will make U.S. compliance easier regardless of laboratory size while facilitating standardization across laboratories internationally.
• **September**
  - The checklists were improved and now include:
    - Changes to clarify the applicability of HER2 predictive marker tests for IHC, ISH, FISH, CISH, and SISH in the following checklists, mostly in the notes section of the Anatomic Pathology, Cytogenetics, and Molecular Pathology accreditation checklists.
    - Low-impact enhancements to the All Common, Hematology, Histocompatibility and Limited Services checklists.

7. **CAP INSPECTOR RECOGNITION PROGRAM**
   - The CAP Inspector Recognition Program was launched in 2010 to acknowledge and honor the dedication of CAP inspectors for their commitment to maintain CAP’s accreditation standards through peer inspections.
   - More than 10,000 inspectors will be recognized in the November edition of CAP TODAY.
   - The recognition categories along with the number of inspectors who qualify include:
     - Three or more inspections 2009-2011 (2,343)
     - Three or more inspection in 2011 (307)
     - Fifteen or more inspection in 2011 (15)
     - Twenty or more inspection performed by team Leaders and team members in 2011 (14)
   - The recognition program will be administered according to these categories via crystal plaques, inspector pins, inspector names badges, and personalized, embossed certificates of recognition.

8. **50th ANNIVERSARY**
   - CAP President Stanley J. Robboy, MD, FCAP, devoted his September 2012 CAP TODAY President’s Desk column to the accreditation program’s 50th anniversary. He wrote: “So if someone asks where you’re from, tell them you come from a place where continuous quality improvement and patient safety are in the cultural DNA. Tell them you come from a place where there are no shortcuts to excellence. Tell them you come from a place where a person’s finest legacy is an abiding interest in doing good. Then they’ll know they’ve met a pathologist whose energies and commitments honor a legacy of quality, consistency, and innovation in the interest of medical progress and patient safety.”
   - More than 500 people registered for the 50th anniversary reception at CAP ‘12 in San Diego. David L. Booker, MD, FCAP, shared brief remarks with the crowd and focused on the fact that CAP Accreditation continues to grow and evolve to meet the challenges of a changing health care and technology landscape – just as we’ve always done, so the celebration and hard work will not end. Further, he remarked that CAP accreditation is an important component of how we have transformed, transform, and will transform.
   - Plans are underway for a November 28 reception at the first CAP-accredited laboratory in Birmingham, AL. CAP President Stanley J. Robboy, MD, FCAP, will be on hand to honor the laboratory and its commitment to the highest standards in laboratory quality.
1. **Learning Strategy Update—Portfolio Refinement**
   At its November meeting, the COE will review CAP Learning’s portfolio and discuss the extent to which our product mix supports our strategic goals and is aligned with the individual pathologist market, as well as the broader learning market for laboratory professionals. The Council will review highlights from the 2010 Learning Strategy research, additional findings from more recent education research and market results over the last two years.

2. **Advanced Practical Pathology Program (AP³) Status Update and Schedule**
   Both the September Ultrasound-guided Fine Needle Aspiration (USFNA) Workshop and October Laboratory Medical Director (LMD) Workshop were well attended. In addition, participants continue to provide extremely positive feedback on the learning experience.

   **2013 AP³ Workshop Schedule**

<table>
<thead>
<tr>
<th>Program</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound-guided Fine Needle Aspiration (USFNA)</td>
<td>April 6-7</td>
<td>Dallas, TX</td>
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<tr>
<td></td>
<td>May 18-19</td>
<td>Engle Wood, NJ</td>
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<tr>
<td></td>
<td>September 28-29</td>
<td>Las Vegas, NV</td>
</tr>
<tr>
<td>Laboratory Medical Director (LMD)</td>
<td>April 11-12</td>
<td>Chicago, IL</td>
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<tr>
<td></td>
<td>September 19-20</td>
<td>Chicago, IL</td>
</tr>
<tr>
<td>Predictive Factors Testing (BPFT) and Multidisciplinary Breast Pathology (MBP)</td>
<td>November 2-3</td>
<td>Chicago, IL</td>
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</table>

Work on the Prostate AP³ continues. Course development for two of the seven online SAMs is underway. The program is anticipated to release in Q4 2013 or early 2014.

The Council will continue discussing CAP’s approach to the Renal and Pulmonary programs at its November meeting. This will follow a review of program performance data (registrations, certificates awarded, evaluation results, etc.), proposed AP³ success criteria, and the proposal/decision process for new AP³s.

3. **Pharmacogenomics: From Concepts to Cases Series**
The Pharmacogenomics program, introduced at CAP’12, consists of four foundational courses that provide key genetic and pharmacologic principles as well as six in-depth case studies in which participants review established scientific data, probe efficacy issues, and learn the latest developments across a range of diseases and therapies. Participants earn up to 16 CME/SAM credits and the foundational courses are approved for Canada CPD credit. Three of the four foundational courses released in September and the final core course is in development. The six case studies are scheduled to release every four months; Regulatory Compliance will be available in February 2013.

4. **Learning Management System (LMS) Upgrade Discovery**
   CAP Learning recently began a discovery project to identify an appropriate vendor to upgrade or replace the current learning management system. The project consists mainly of vendor landscaping, Request for Proposals and final vendor selection. The drivers for this project are:
   a. to improve accessibility of CAP Learning courses using PC and MAC computers as well as tablets
   b. to improve CAP’s ability to package learning products in a variety of ways in meeting the diverse needs of members and laboratory professionals
   c. to integrate social media tools and concepts into CAP Learning products.

   The team expects to complete the discovery phase in February 2013 with the final recommendation on a vendor/solution.

5. **CAP’12 Recap**
   CAP’12 offered one-hundred and three CME/CE courses over the four-day meeting, including a track in pulmonary pathology. Attendance in most courses was excellent. Other program highlights included video microscopy tutorials for residents, several courses focused on transformational topics and interactive course designs (e.g. participant role play, small group breakout discussions). Dr. Phil Cagle moderated the scientific plenary, **Breakthroughs in Molecular Testing of Lung Cancer: A Pathologist’s and a Patient Advocate’s Perspective**, which featured Dr. Marc Ladanyi and Ms. Kim Norris as speakers. Updated course presentations are available on the CAP’12 web site for download. CME attendees have until March 31, 2013 to access the materials and claim their continuing education credit.

   Results of the CAP’12 overall meeting evaluation were very positive. The majority of participants were satisfied with the degree to which the course content was practical and useful (95%) and offered up-to-date and timely information (96%), the effectiveness of the faculty (94%), and overall value (95%) of the education courses.

6. **Accrediting Council for Continuing Medical Education (ACCME) Reaccreditation Process**
   CAP Learning staff is preparing for ACCME reaccreditation in 2014. The ACCME identifies, develops and promotes standards for quality continuing medical education and recognizes organizations as CME providers. ACCME reaccreditation is necessary for CAP to continue providing CME for its courses. The College was accredited in 2008 and received 6-year Accreditation with Commendation, the highest accreditation awarded.

   Staff is updating education policies and writing a self-study report that documents CAP’s compliance with accreditation requirements and describes exemplary performance as well as areas for improvement. The COE will review and submit policy changes for the Board of Governor’s review and approval early next year, and will provide guidance and input on the self-study exemplary compliance documentation. CAP Learning staff will submit a list of all CME activities conducted during the last six years, from which the ACCME selects a subset of activities for detailed review. ACCME surveyors review the self-study report and activity files and then conduct an
interview with key CAP Learning members and staff in Q1 2014. The accreditation decision is expected later that year.

7. **Publications**
CAP Press released a new publication, *Atlas of Paleopathology: Autopsies in South American Mummies*, at the beginning of October. Written by Enrique Gerszten, MD, FCAP, and colleagues, the photograph-rich text documents 40 years' experience in excavating and examining mummified remains from pre-Columbian civilizations.

CAP Press hosted its first “Meet the Authors” sessions at CAP’12. The sessions were well attended and contributed to an increase in on-site book sales relative to 2011.

8. **Periodicals**
Dr. Cagle continues to pioneer new directions for the journal, adding new sections and section editors to more fully engage cutting edge developments in the specialty. The Archives and CAP TODAY are performing with the best financial results in several years, with excess revenue over expenses for the combination in the black as of the end of September. Digital revenues, a robust return to health of the classified advertising enterprise, and the stalwart efforts by the new sales team (installed in full in April) are all key elements in this performance. A recent research study conducted on behalf of CAP TODAY by Kantar media among the section managers and supervisors demonstrates CAP TODAY’s leadership in all categories of this important audience.
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To: House of Delegates Steering Committee

Topic: CGPA Update (November/December 2012 Report)

From: Richard C. Friedberg, MD, PhD, FCAP  
Chair, Council on Government and Professional Affairs

John H. Scott  
Vice President, Division of Advocacy

Date: January 3, 2013

Federal

Fiscal Cliff Law - Medicare physician payments will not be cut by 26.5% now that the American Taxpayer Relief Act (H.R. 8) was signed into law. This fiscal cliff deal delays the Medicare physician fee cuts under the sustainable growth rate (SGR) for a year. Under this package to avert tax increases and deep spending cuts in health care as well as defense spending, the sequestration cuts will be deferred for two months. Physicians are facing a 2% cut in Medicare cuts under the budget sequestration process. The cost to delay the SGR cuts until Jan. 1, 2014, as well as other Medicare extender provisions, is estimated to cost $25 billion. This spending will be offset through a number of provisions, including extending the statute of limitations from 3 to 5 years for recouping overpayments and elimination of unobligated funds for health insurance co-ops authorized by the health care reform law. In addition, payments for advanced imaging services will be reduced based on a change in assumptions regarding the utilization of equipment.

2013 Medicare Physician Fee Schedule

Technical Component Decrease - The government is now acting on its charge to combat health care overutilization and escalating spending, as was evident in the 2013 Medicare Physician Fee Schedule final rule, which featured payment cuts for many specialty providers—including pathologists—and revaluation of numerous high volume codes, including a 52% decrease of the technical component (TC) of the surgical pathology CPT code 88305. The final rule also decreased the TC of some other codes in the surgical pathology family (88300-88309) and will lead to reimbursement changes to other pathology codes due to indirect costs. The 2013 final rule estimates that the total cut in Medicare funds to pathologists is 6% after including the change to pathology code values, together with the implementation of primary care increases and other practice expense methodology changes.

Direct Practice Expense- CMS is also weighing further cuts in regard to direct practice expense recommendations. Specifically, the agency is looking closely at the quantities and items included in these recommendations for the surgical pathology family 88300-88309 that were developed for each code in the family based on the number of blocks used each time a service is reported. CMS accepted the RUC’s recommendation based on the number of blocks on an interim basis for 2013. However, for 2014, the agency is seeking additional evidence regarding the appropriate number of blocks for each service, as it is concerned about the accuracy of the number of blocks assumed for each CPT code. If these concerns are not addressed, then the agency could decide to enact further payment reductions in 2014. The CAP will work with the RUC and other stakeholders to provide this requested information to CMS to prevent additional cuts in the 88305 code family for 2014 and beyond.
**Molecular Code Placement** - In addition to the code payment changes, the final rule also announced that the molecular diagnostic “stacking” codes currently used for billing molecular pathology services to Medicare beneficiaries will be eliminated next year, replaced by new analyte specific CPT codes on the Medicare Clinical Laboratory Fee Schedule (CLFS). CMS did not publish payment rates for these codes, which instead will be paid by gap fill methodology for 2013. The agency did, however, provide a new G-code for use by physicians, specifically pathologists, asserting that physician interpretation of these tests is sometimes medically necessary. CMS will monitor the use of the new HCPCS II G-code. CAP led a multi-stakeholder effort to develop the CPT codes, and supported their placement on the Physician Fee Schedule. The final rule also discussed payment for interpretation and preparing the report when non-physicians perform this service. Specifically, CMS stated that the interpretation and report service of non-physicians associated with the molecular pathology codes is captured in the CLFS payment and no separate payment will be made for PhD interpretation.

**President Obama Signs PT Referral Bill Into Law** - On Dec. 4, President Obama signed the “Taking Essential Steps for Testing Act” into law, giving CMS greater discretion in determining sanctions against laboratories violating CLIA rules on referral of proficiency testing (PT) samples to other labs for analysis. The Senate passed the TEST Act (S. 339) on November 14, while the House passed a companion bill (H.R. 6118) on Sept. 19. CMS and the College both supported the bills, based on concerns that CMS had no alternative under CLIA but to enact severe mandatory sanctions on laboratories violating CLIA PT referral rules, even in the case of inadvertent violations. Furthermore, the CAP had joined other stakeholders in noting the severity of the mandatory sanctions, which can mean that even inadvertent violations may result in the revocation of a lab’s CLIA certificate as well as a two-year ban on operating or owning a laboratory for laboratory directors and owners.

**Meaningful Use Update** - Through recent discussions with the College, CMS officials have clarified that by relying on data entered by others into the ambulatory certified electronic health record (EHR), pathologists may qualify for incentives under the federal Meaningful Use program. Officials also explained that pathologists, like other eligible providers, need to meet the required objectives by using the data in the certified EHR or an applicable exclusion in order to earn an incentive. This is expected to impact pathologists primarily at academic medical centers, several of whom have already reported to the CAP that they have attested to Meaningful Use and received incentives through this pathway. In addition, CMS officials indicated that the agency is developing a guidance on specialists and Meaningful Use, and will continue to clarify what a patient encounter means in the context of this federal program if a provider doesn’t have face-to-face contact with patients. CAP continues to believe that it will be extremely difficult for the vast majority of pathologists to meet Meaningful Use requirements.

**CAP Requests HHS Clarify Genetic Testing’s Inclusion in Essential Health Benefits** - The College is recommending that the Department of Health and Human Services (HHS) clarify that genetic and genomic testing be included as a “laboratory service” now required to be covered by qualified health plans under a state or federally operated health exchange, as mandated by the Patient Protection and Affordable Care Act (ACA) reform law. The CAP comments are in response to a Nov. 26 HHS proposed rule governing the operation of state health exchanges and the standards applicable to qualified health plans made available through these state or federally operated exchanges.
of Pathologists (WSSP). The CAP has worked with state pathology societies to elicit similar opinions on EHR donations from five other states: New York, New Jersey, Missouri, Pennsylvania, and West Virginia.

**New Jersey Genetic Counselor Legislation** - Lawmakers in the New Jersey Assembly Regulated Professions Committee unanimously passed a CAP and New Jersey Society of Pathologists’ (NJSP) supported bill to clarify that a genetic counselor’s scope of practice does not include the statutory authority to “interpret” genetic tests, as is currently provided. The bill, A. 1757/S. 555, also categorically exempts all physicians from the licensure law. The bill, S. 555, which passed the full Senate in June and will now go to the full Assembly, amends the state’s current genetic counselor licensure law to conform to the scope of practice agreement between the CAP and the National Society of Genetic Counselors (NSGC).
MEMBER RECRUITMENT AND RETENTION

1. Membership Data

*The College determines its segment data and membership total in January of each year. The January 2012 bolded numbers report the total membership achieved in 2011.

CAP Membership is fluid throughout the year. Final, accurate member total/segment data for 2012 will be reported in January 2013.

**As a result of work being done for the Enterprise Program Platform data migration into the new Oracle customer database, the CAP dropped members for non-dues payment on April 1, 2012. This was four months earlier than previous years.

MEMBER BENEFITS AND SERVICES

2. CAP ’12 – THE Pathologists’ Meeting™

- **Registration:** CAP ’12 broke all CAP annual meeting records, with a record number of registered pathologists, exceeding our goal by 13.1%!

- **Exhibitors:** CAP ’12 hosted exhibiting companies on our sold-out exhibit floor and a number of exhibitors had to be turned away. More exhibit space will be available for CAP ’13.

- **Education:** Course curriculum included 103 courses, taught by 145 faculty experts. Courses this year included two video microscopy courses geared exclusively for residents.
3. Fall 2012 CAP Residents Forum (RF) Meeting - September 8, 2012

- **Registration:** Residents representing the highest number of programs ever represented at a single RF meeting – attended the Fall 2012 RF meeting in San Diego, California immediately prior to CAP ’12.

- **Evaluation:** Attendees rated the RF meeting high on their evaluation responses as indicated below.
  1. The morning Joint Session with the HOD met my needs as an RF delegate
     - 87% Agreed — Strongly Agreed (41%) or Agreed (46%)
  2. The RF sessions met my needs as a delegate
     - 95% Agreed — Strongly Agreed (54%) or Agreed (41%)
  3. Overall, how satisfied were you with the RF meeting?
     - 96% Satisfied — Very Satisfied (46%) or Satisfied (50%)
  4. Was this your first time attending an RF meeting?
     - Yes (46%)
     - No (54%)
  5. How likely are you to attend a CAP RF meeting that is not planned in conjunction with a major annual meeting (e.g., CAP or USCAP)?
     - 9% Very Likely
     - 17% Likely
     - 24% Somewhat Likely
     - 26% Only Slightly Likely
     - 24% Not at All Likely

4. **Peer2peer (p2p) Practice Roundtable Conversations**

- **Positive Peer2peer (p2p) Feedback**
  Due to the confidential nature of the discussions at peer2peer events, it is often difficult to report on the positive outcomes generated during the peer2peer conversations. However, the participants involved in a recent peer2peer event have granted permission to use their names and share their story.

At the beginning of October, Rodolfo Laucirica, MD, FCAP, Cytopathology Fellowship Director, Baylor College of Medicine, served as the Conversation Leader for the peer2peer Practice Roundtable Discussion held at the University of Miami. Richard Cote, MD, FCAP, Chair of the Department of Pathology at the university and Phillip Chen, MD, PhD, FCAP, Professor and Vice Chairman of Pathology were the hosts of the conversation.

Some of the concerns identified by Dr. Cote’s group included: workforce shortages, future recruitment, residency issues, and the future of genomic/genetic testing. The group also expressed a fear that residents could not keep up with necessary training and discussed the negative impact that had on their institution and on the specialty of pathology. During an exchange of ideas, Dr. Cote’s group and Dr. Laucirica determined that the
development of a cross institutional program, allowing for shared training and collaborative research, building on the specific skill sets and strengths of each program, could improve residency training for both programs. As a direct result, they have begun planning an exchange of trainees between their respective universities.

Dr. Laucirica was thrilled with the implications of this new approach to training. The possibility for cross fertilization, throughout multiple institutions, was acknowledged as offering great potential down the road. Such collaboration could be taken to the next level, i.e. the education council, and could offer trainees knowledge of “another language/another culture, making everyone all the richer for it.”

Dr. Phillip Chen stated that the practice is, “grateful for the College’s support and Dr. Laucirica and the CAP partner’s leadership and participation in the event. [The] pathologists enjoyed the event very much and viewed this type of discussion as beneficial and critical. As a follow up, Dr. Cote, our chair and the host of the peer2peer, has now established an internal monthly practice management dinner to continue the conversations in a format modeled after the peer2peer program. We will consider expanding this in the future to include fellow pathologists in our region.”

What is solidified by this experience is the true benefit that comes from members engaging with one another to find support and solutions for the security of the future of pathology.

- 30 states represented.
- 55% of events held at community hospitals, 25% held at academic institutions, 6% held at stand alone laboratories, 14% held in other settings.

5. **New in Practice Career Navigation Portfolio**

- The New in Practice Committee continues to develop a portfolio of benefits/services focused on the specific needs of the new in practice pathologist at each of the sub segments identified below:
  - Pathologists in first year of practice (Transition to work)
  - Pathologists in practice 2-3 years (Establish base)
  - Pathologists in practice 4-5 years (Expand circle of influence)
- The first completed entry in the portfolio is a webinar: Career Transitions for the New in Practice Pathologist: how to professionally move from one job to the next, presented on October 30, 2012 at 1:00 pm. Speakers: Chad Rund, DO, FCAP (for NIP perspective), Gene N Herbek, MD, FCAP, Robert L Breckenridge, MD, FCAP, (for employer perspective). Content areas include:
  - Identification of the best time to leave a job
  - What to look for in the next job
  - How to find the next job
6. Practice Management

- **Practice Management Directory** - The Practice Management Directory has been redesigned to improve access for pathologists and the presentation of the firms listed in the directory. The redesign included allowing non-members to access the directory and reducing the number of clicks required to get information about the firms. As a firm renews its listing in the Directory, its logo is added to the new Directory page. The Directory is a key resource in responding to member questions that require resources beyond those that CAP provides. Three persons, two of whom must be members, have referred the firms listed in the Directory.

- **Just In Time (JIT) Practice Management Resources** - [cap.org/practicemanagement](http://cap.org/practicemanagement) continues to be improved with better organization of the information and additional links to resources that are commonly used to respond to pathologists’ questions. For example, there is now a link to CMS Physician Fee Lookup in the Coding and Payment section.

- **Transformation Strategy** – Practice Management is anticipating playing a key role in helping pathologists’ practices implement the Transformation Strategy and the Promising Practice Pathways™. More information regarding these plans will be incorporated into the Transformation Initiatives discussion during the Board of Governors meeting.

7. The CAP Engaged Leadership Academy (ELA)

- The 2012 CAP Engaged Leadership Academy (ELA), scheduled to take place on December 1-3 at the Omni Hotel in Chicago, is the advanced next ‘generation’ of the College’s highly valued Spokespersons Training Program. The ELA has been designed to provide College leaders with dedicated time to practice and hone skills in presenting critical contributions to patient care as a physician whose specialty is pathology.

- During this two-and-a-half day program, members will work together and participate in hands-on training and exercises (some facilitated by their own experienced peers). The emphasis, in both large and small group sessions, is in learning by doing. Training topics will focus on communication and advocacy skills, Transformation messaging (particularly Promising Practice Pathways), and social media.
8. **MYBIOPSY.ORG**
   - The College continues to develop new MyBiopsy patient information sheets which serve as a resource for pathologists and their clinical colleagues as well as patients to assist in understanding a cancer diagnosis.

New Biopsy Sheets Posted
- **Bone**
  - Osteosarcoma
  - Chondrosarcoma
  - Ewing sarcoma
- **Gallbladder**
  - Adenocarcinoma
- **Liver**
  - Hepatocellular carcinoma
- **Kidney**
  - Renal cell carcinoma
- **Stomach**
  - H. pylori
  - Barrett’s Esophagus
  - Stomach adenocarcinoma
  - Stomach gastrointestinal
- **Uterine Cancer**
- **Breast**
  - Fibroadenoma of the Breast

- **Web Traffic**

Below is a table comparing the 2012 Y-T-D MyBiopsy Web traffic to 2011 Y-T-D Web Traffic.

<table>
<thead>
<tr>
<th></th>
<th>2012 (Jan 1 - Oct 17)</th>
<th>2011 (Jan 1 - Oct 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNIQUE VISITORS</strong></td>
<td>200,413</td>
<td>99,310</td>
</tr>
<tr>
<td><strong>PAGE VIEWS</strong></td>
<td>230,592</td>
<td>116,483</td>
</tr>
</tbody>
</table>

The total number of unique visitors to MyBiopsy since the inception of the website on January 1, 2007, is more than 540,000 (542,657), and the total number of page views is more than 640,000 (641,369). Currently, there are 151 “likes” on the MyBiopsy Facebook page.

Below is a listing of the top five most visited MyBiopsy pages from **January 1 - October 17, 2012**.
1. Colon: Adenomatous polyps
2. Colon: Hyperplastic colon polyps
3. Brain: Glioblastoma
4. Cervical Cancer: Cervical adenocarcinoma
5. Cervical Cancer: Cervical squamous cell carcinoma

9. CAP Public Position Statements
The following two CAP public positions statements, which originated in the Member and Public Communications Committee, have been reviewed and approved by the Council on Scientific Affairs (CSA) as well as the Council on Government and Professional Affairs (CGPA).

- The HPV and Cervical Cancer Prevention Public Position Statement
  - The statement was updated due to the March release of new screening recommendations by the American Cancer Society, ASCCP, and the American Society for Clinical Pathology (ASCP)

- Sickle Cell Trait in the Athlete Public Position Statement
  - The American Society of Hematology changed its policy on this topic, which resulted in the CAP revisiting its public position statement.

10. NewsPath® Editorial Board
The NewsPath Editorial Board (NEB) continues to meet bi-monthly via conference call and has one in-person meeting each year in conjunction with the fall Member and Public Communications Committee meeting.

- Articles and Podcasts
  - A new NewsPath article and podcast is posted on the first of each month on the CAP’s website. The podcast is also posted on iTunes.
  - Articles and podcasts are completed through March 2013, with 24 additional articles in various stages of development.

- Outreach to CAP Residents
  - The NEB continues to promote NewsPath to residents as an opportunity to receive a by-lined article and the chance to work with a scientific mentor through the Council on Scientific Affairs (CSA).
  - NEB members promoted NewsPath at CAP’12 during the networking reception.

- Outreach to Non-Pathologists
  - One of the NEB’s goals is to promote the NewsPath articles and podcasts to non-pathology clinicians. The following NewsPath articles have been sent to the associations below:
    1. American Society of Gastroenterology
College of American Pathologists

July 2012: “Dysplasia in Barrett’s Esophagus—An Update on Grading,” written by Syed Gilani, MD

2. American Academy of Otolaryngology
   March 2012: “Throat Cancer and Human Papillomavirus (HPV) Infection,” written by Feriyal Bhajee, MD

3. American Congress of Obstetricians and Gynecologists (ACOG)
   January 2012: “Cervical Cancer Screening—Markers of Cervical Carinogenesis,” written by Nicole Riddle, MD

- Web Traffic
  Below is a table comparing the 2012 NewsPath Y-T-D Web traffic to the 2011 NewsPath Y-T-D Web traffic. The number of visitors and views to NewsPath articles and podcasts increased by 33 percent from 2011 to 2012.

<table>
<thead>
<tr>
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<th>2012 (Jan 1 - Oct 17)</th>
<th>2011 (Jan 1 - Oct 17)</th>
</tr>
</thead>
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<tr>
<td>UNIQUE VISITORS</td>
<td>24,605</td>
<td>18,860</td>
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<tr>
<td>PAGE VIEWS</td>
<td>28,174</td>
<td>21,965</td>
</tr>
</tbody>
</table>
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1. **REVENUE, STEP AND MIDDLE GROUND**
   The 2012 Proficiency Testing (PT) revenue continues to exceed its targets:
   - 52 new PT products have been introduced for 2013.
   - Progress continues for Evalumetrics and DigitalScope initiatives.
   - An update on **eLAB Solutions Connect** is provided as a separate information report.

   The order renewal campaign for the 2013 Survey year has launched. Catalogs and order renewal forms were sent to customers the week of August 27. As of October 21, we have received $21.1M in PT orders and are ahead of our pace from 2012.

2. **Consortium for Harmonization of Clinical Laboratory Results (ICHCLR)**
   The CSA has been granted approval to advance a new initiative in cooperation with the American Association of Clinical Chemistry (AACC) through becoming a Founding Member of the Consortium for Harmonization of Clinical Laboratory Results (ICHCLR). At the recent Executive Committee meeting, funding at the $50,000 level was approved to join this Consortium. Part of the core mission of the CSA and the College as a whole is to drive standardization of clinical laboratory results. This is evident in the PT Program, the Accreditation Program and across the College. In keeping with that mission, the CSA felt it was important to be part of this initiative as a Founding Member. The ICHCLR will be hosted by the AACC which will serve as the Secretariat. As the Secretariat/Host Organization, the AACC will provide the infrastructure and management of administrative, financial, accounting, and marketing services. The Consortium will be governed by a Council whose members will be the representatives from the Founding Organizations. The Council will be responsible for the administrative oversight of the Consortium to ensure efficient and effective operations, adoption and implementation of policies such as antitrust policy, policy on cooperation with other organizations, and policies and procedures of all other committees and working groups.
3. **CSA Official Outbound Liaisons**

At the request of CAP President Stanley J. Robboy MD, FCAP, the CSA brought a discussion item forward to the Executive Committee on the topic of Official Outbound Liaisons. This topic was considered in the context of how these existing and often long standing relationships of the College can be made more comprehensive not only for the CSA but across the College. In support of this discussion, the CSA provided details on how it manages the many liaisons, how liaisons report information and how feedback is shared across the College. After Official Outbound Liaisons participate in scientific meetings on behalf of the College, reports are forwarded to the Standards Committee which engages in a primary level of review and compiles an executive report highlighting key areas of interest for the CAP as a whole. This report is routinely shared with CAP Board Members, other Councils and key stakeholder groups via an information report to the Executive Committee and to the Board of Governors. The Standards Committee also uses this information to create short, engaging articles which are included as ongoing features in *CAP Today* entitled, *Shorts on Standards*. By doing this, tens of thousands of readers are reached.

**ATTACHMENTS**

## EXECUTIVE SUMMARY

### Outbound Liaison Meetings

Reports Received from January 1 – June 30, 2012

<table>
<thead>
<tr>
<th>Organization</th>
<th>Liaison</th>
<th>Meeting Date</th>
<th>Reviewer</th>
<th>Strategic Messages or Controversies</th>
</tr>
</thead>
</table>
| **Foundation for the Accreditation of Cellular Therapy (FACT) Professional Relations Committee** | David Feldman, MD              | 3/21/12      | Standards Committee       | 1. There are currently 185 cellular therapy programs and 32 cord blood banks accredited. An additional 13 programs and 21 banks have applied for initial accreditation.  
2. The 5th edition of the FACT-JACIE International Standards for Cellular Therapy Product Collection, Processing, and Administration was issues on March 1, 2012.  
3. The CAP Histocompatibility Committee asks: “What can CAP do to gain recognition/acceptance by FACT for HLA laboratory accreditation?” This is being addressed.  
4. AABB continues to advance its presence in the regenerative medicine/cell therapy space through audio conferences, specific sessions at the annual meeting, publications, webinars, and through its accreditation activities.  
5. AABB is planning to enhance its presence in the cellular therapy arena. |
| **US Technical Advisory Group (TAG) to the ISO Technical Committee (TC) 212** | Al Hartmann, MD                | 3/24/12      | Standards Committee       | 1. The Standards development process has 5 stages: Preparatory, Committee, Inquiry, Approval, and Publication. Comments are balloting are allowed at only the first 3 stages.  
2. A work item proposed by the Korean Delegation was: New Work Item Proposal (NWIP) Nucleic acid based in vitro diagnostic tests for detection and identification of microbial pathogens. There was discussion on whether the NWIP should be developed under Work Group (WG)4, Microbiology Susceptibility, or under a new WG 5. |
# EXECUTIVE SUMMARY

**Outbound Liaison Meetings**

**Reports Received from January 1 – June 30, 2012**

<table>
<thead>
<tr>
<th>American College of Medical Genetics (ACMG)</th>
<th>Larry Jennings, MD PhD</th>
<th>Gaurav Sharma, MD</th>
</tr>
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<tbody>
<tr>
<td>1. ACMG has officially changed its name to “American College of Medical Genetics and Genomics”.</td>
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<td>2. Dr. Wayne Grody (CAP member, molecular pathologist, clinical geneticist and President of ACMG) has recommended that ACMG embrace “-omics” of every kind, which highlights the aggressive move of geneticists to areas other than heritable genetics.</td>
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<tr>
<td>3. Many presentations focused on the application of next generation sequencing (NGS) to the clinical laboratory. The meeting also had a strong emphasis on the increasing role of bioinformatics for healthcare professionals.</td>
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<tr>
<td>4. Dr. Jeffrey Kant concluded last year’s ACMG synopsis by saying, “If we don’t step up, others will.” It appears that others have stepped up, and pathologists need to make bigger strides if we hope to also be recognized as experts in the age of genomics.</td>
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3. **Key points for CAP attention:**
   - i. It is critical to nominate CAP members to working groups where the most influence of the final product occurs.
   - ii. CAP should nominate a member to be on WG5 molecular methods if this WG is formed.
   - iii. Inform CAP members interested in the standard setting process how the standard development process occurs in ISO.
   - iv. The CAP needs to monitor and comment on those standards that are critical to the practice of pathology in the US at an early stage to get the most benefit in changing the technical content to something favorable to laboratory practice in the USA.
**EXECUTIVE SUMMARY**  
Outbound Liaison Meetings  
Reports Received from  
January 1 – June 30, 2012

| AABB’s FDA Liaison Committee | S. Gerald Sandler, MD | 4/12/12 | Dr. Elizabeth Van Cott | The proposal approved by the Transfusion Medicine Resource Committee to ask FDA whether the tie tag could be used to include historical phenotyping of the donors prior donations, as well as the current donation was discussed.  
Recently the practice of using tie-tags has been questioned. We understand that FDA interprets 21 CFR 606.121(j) to disallow the use of tie-tags for this purpose, however, he language does not preclude the use of tie-tags for other information that is not required by the CFR to be on the blood bag label. |
|---|---|---|---|---|
| Next-generation DNA sequencing as a tool for clinical decision-making in cancer patient management workshop by NIH/NCI Biomarker Consortium | Chung-Che (Jeff) Chang, MD, PhD | 5/3 – 5/4/12 | Gaurav Sharma, MD | The following consensuses were reached after the workshop:  
1) NGS of whole genome and/or transcriptome will remain primarily research in the next 3 to 5 years; however, NGS of targeted genes which are clinically actionable/useful is already moving into clinical laboratories.  
2) 500 x coverage for genes of interest is needed for cancer genes given the existence of background normal cells and tumor heterogeneity.  
3) Analytic parameters should be established by the laboratories. However, such parameters will be quite different from the current practice, i.e. not analyte-specific but rather method-specific. It is not feasible to validate each sequenced region within each NGS gene panel which may contain hundreds of regions.**  
4) PT/QC materials should also be method specific rather than analyte-specific since the panel may contains hundreds of genes and not feasible to have PT/QC for each gene. PT/QC materials should focus on clinically actionable genes.**  
5) CDC and FDA are working on reference/standard materials for NGS**  
6) Guide line for performing NGS including how to store NGS data is required and is currently undergoing in CDC and other societies. Storing of NGS data may be performed like storage of paraffin blocks. **|
EXECUTIVE SUMMARY
Outbound Liaison Meetings
Reports Received from
January 1 – June 30, 2012

7) Build a registry to deposit all the genetic variants identified by NGS of clinical samples and establish a database to link these variants with clinical significance.

8) Inform consent should be considered for performing extensive panel of cancer related genes since incidental findings of germline mutation may occur and patients should be adequately informed.

**CAP may consider acting on these items.

US-Poland Cooperation on Cancer Research

Kay Washington, MD, PhD

6/3/12 Standards Committee

1. In conjunction with the annual ASCO meeting, I met with members representing several Polish Oncology Societies to discuss the adoption of the CAP Cancer Protocols in Poland.

2. The oncologists will lead in the creation of a multi-disciplinary steering committee to direct the adoption of the CAP Cancer Protocols in Poland. In order to encourage use of the Cancer Protocols, the steering committee will assess the possibility of pay for performance incentives, grant funding and education.

3. Some challenges regarding the adoption of the protocols were identified:
   i. Poland currently has 300 active pathologists and there are over 140,000 new incidences of cancer diagnosed annually. These pathologists often float between 9-10 different institutions. Understandably, this large workload negatively impacts the turnaround times and diagnostic accuracy.
   ii. There is a lack of accreditation for cancer centers and laboratories in Poland.
   iii. IT resources are currently limited, making the support of electronic synoptic reporting difficult, although the launch of a new EMR project makes timing auspicious for electronic reporting. The upcoming eFRM product from CAP STS might address this issue as the new tool will be a web-based program.
The emergence and the acceptance of this technology in routine clinical medicine would be significant step because it would provide the pathologist and the clinician the possibility of a $1,000 genome with single-day turnaround time.

The human genome is just over 3 billion base pairs long, and the recent advances in genomic medicine can be traced back to the sequencing of the reference human genome that was completed in 2003. This feat was accomplished using bacterial artificial chromosome (BAC) cloning that relied on complex and time-consuming techniques. Since then the sequencing technologies have moved away from bacterial cloning toward a streamlined and parallel direct sequencing model, often referred to as next-generation sequencing. Most platforms of NGS work by breaking the DNA into small strands and generating a fragment library by annealing platform-specific linkers to the fragments of DNA. Single strands of the fragment library are partitioned, amplified, and sequenced in parallel. Once sequencing is complete, specialized software is able to capture and analyze the sequence reads and localize them on the reference genome and assemble the entire target sequence. Being parallel and not dependent on any plasmids or bacterial cultures, this approach is quicker and cheaper and brings with it the possibility of a $1,000 genome with single-day turnaround time.

The emergence and the acceptance of this technology in routine clinical medicine would be a significant step because it would provide the pathologist and the clinician access to DNA information that could be useful in risk-stratification, diagnosis, and management of diseases and therapies that are influenced by the genome of an individual.

However, significant technological and other barriers must be overcome before NGS can go mainstream. At the May meeting, participants discussed the challenges of managing (and strategies to do so) the sheer amount of genomic data that would have to be converted to actionable information that can guide clinical care. The scale of information can be reduced by limiting NGS to specific targeted gene panels instead of attempting to sequence and analyze the entire exome or genome. In fact, this approach has become available at a few academic institutions and several others are evaluating it now. The CDC and other organizations are also developing guidelines for managing and archiving clinical NGS data.

The second biggest challenge is building a consensus on method validation and proficiency testing for NGS. The meeting was abuzz with discussions on analytical issues such as sensitivity, specificity, reproducibility, limit-of-detection, and depth of coverage with respect to a genetic analyte. For oncology-related testing, participants agreed that a gene of interest should have a minimum of 500× coverage. Since different laboratories may use NGS for a multitude of different gene targets, it was suggested that method validation and PT be method-specific rather than analyte-specific, the latter being the predominant approach in clinical practice today. Further, the CDC and FDA are creating reference standards that may be used for proficiency testing. The CAP will begin next year to develop a proficiency test for NGS.

The workshop participants emphasized the need for continued public support of the creation and curation of standardized online NGS-related databases that laboratories can access to analyze and report sequence variants. It was hoped that these databases...
will be expanded by ever increasing NGS case numbers and enriched by additional clinical information and annotation. This information would be invaluable in evaluating outcome data from clinical trials and linking efficacy of drugs with specific genetic variants.

Overall, this meeting was an extremely productive gathering of the individuals and organizations that are facilitating the introduction of NGS technologies for clinical purposes. The participants agreed that NGS-enabled genomic medicine has the potential to completely change the practice of medical diagnostics and patient management. Information obtained by NGS would be critical in diagnosis, risk-stratification, therapeutic management, and monitoring of therapeutic response, and the pathologist would have a critical and central role in generating, managing, and interpreting genetic information for the rest of the health care team.

Dr. Sharma, of the University of Michigan Health System in Ann Arbor, is a member of the CAP Standards Committee. Dr. Jennings, of the Ann & Robert H. Lurie Children’s Hospital of Chicago, is chair of the CAP Molecular Oncology Committee. Dr. Chang, of Florida Hospital in Orlando, is a member of the CAP Molecular Oncology Committee and liaison to the NIH Biomarkers Consortium.
Since the last BOG meeting, the TPOSC shares the following:

1. **TPOSC**
   The TPOSC held a meeting on July 20-22, 2012 in Chicago, IL.

   - The meeting accomplished the following:
     - Unanimous approval of the Transformation Strategy that contains three strategic elements and thirteen tactical priorities
     - Approval of a near term strategic focus on strengthening pathology practices. Helping them create greater value, especially in embedding new genomics and informatics capabilities in their work, and getting paid for this in the context of coordinated care

   - The next face-to-face meeting of the TPOSC is October 26-28, in Dove Mountain, AZ. Objectives for that meeting include:
     - Understand the elements of the Transformation Strategy, including key focus areas, prioritized initiatives, and sources of funding
     - Obtain approval to take the Transformation Strategy (prioritized initiatives and pro forma funding) to the Board in November
     - Elicit input into a proposed set of metrics to track and measure progress against the Transformation Strategy
     - Understand the rollout plan for the Promising Practice Pathways™ and The World Anew (eBook)
2. **CASE 4 CHANGE MODULES**

The Case 4 Change (C4C) and Integrated Team work completed in June. The culmination of that work is being utilized as foundational elements for the Transformation Narrative and Strategy.

- The Transformation Narrative consists of a Prologue and fourteen individual chapters. As of this writing, the progress on the Transformation Narrative is as follows:
  - All fourteen chapters and the Prologue have made their way through the entire editorial review process including Officer and Interviewee approval
  - Seven chapters and the Prologue have had final edits incorporated and are considered completed
  - The Seven remaining chapters are having final edits applied and are expected to be complete by no later than November 2nd
  - In early November, we plan to elicit Board approval of the Narrative content in total (prologue and fourteen chapters)
  - Once Board approved, the Narrative content will be released to Communications for eBook publishing and promotion with a tentative release scheduled for early January

- The Transformation Strategy, which combines a vision for the future of pathology, targeted outcomes for pathologists, and College initiatives is aimed to create a tipping point that will accelerate the rate by which pathologists take control of their economic and professional destinies. Prior to the November Board Meeting, the Transformation strategy (prioritized initiatives and pro forma funding) will be reviewed by and feedback will be incorporated from:
  - CAP Professional Leadership
  - October 26-28, 2012 : TPO Steering Committee

3. **CENTER**

Within the next few months, the Center plans to submit two guidelines for approval and publication:

- Molecular Testing Guideline for Selection of Lung Cancer Patients for EGFR and ALK Tyrosine Kinase Inhibitors: Guideline from the College of American Pathologists (CAP), International Association for the Study of Lung Cancer (IASLC) and the Association for Molecular Pathology (AMP) – In the coming weeks, this guideline will be submitted to the approval bodies of the three collaborating organizations and then to the respective journals for simultaneous publication. CAP, IASLC and AMP will coordinate communication and dissemination of this important guideline that establishes evidence-based recommendations for molecular analysis of lung cancers. The guideline, which addresses which patients and samples should be tested, and when and how testing should be performed is based on a review of over 1500 titles and abstracts from the literature.
Validating Whole Slide Imaging for Diagnostic Purposes in Pathology: Recommendations of the College of American Pathologists (CAP) Pathology and Laboratory Quality Center - This guideline, based upon over 700 literature citations, will recommend validation requirements for whole slide imaging systems (WSI) used for diagnostic purposes. These practical recommendations will help pathologists and other stakeholders answer the question: What needs to be done to “validate” a whole slide digital imaging system for diagnostic purposes before it is placed in clinical service? This guideline will be completed soon by the expert panel and submitted for final approval. Several presentations have already been made at the Association of Pathology Informatics, Digital Pathology Association and American Society of Clinical Pathology to communicate the impending guideline with a robust communication plan in progress.

4. **TPO DIVISION STAFF UPDATES**
   - Ronald Ranauro, Director, Health Information Technology Strategy resigned from the College effective August 10, 2012.

5. **NEXT GENERATION SEQUENCING WORK GROUP (NGSWG)**
   - The NGSWG generated a checklist for standards for clinical NGS testing which was published on July 31, 2012. This set of 18 requirements covers both the Analytical Wet Bench Workflow and the Bioinformatics Workflow for NGS.

   - The NGSWG will be presenting a poster the Association of Molecular Pathology Annual Meeting, October 2012 on the CAP NGS Checklist Requirement. The NGSWG is currently drafting a whitepaper on their recent work and will be submitting this for publication to a journal with wide genomics readership in Q1 2013.

   - The NGSWG will work in collaboration with the Maternal Screening sub-team within the CAP/ACMG (American College of Medical Genetics) Biochemical and Molecular Genetics Committee to develop additional checklist requirements specifically for this clinical testing area for the 2013 version of the checklist.

   - The NGSWG has proposed a product concept for a first NGS proficiency assessment product for methods based NGS testing. This proposal has been approved for a pilot phase project and will be funded substantially through the TPO division. The NGSWG is providing intellectual and subject matter expertise to the internal team consisting of staff from PT, Marketing, Purchasing and the TPO. The material transfer agreements and confidentiality disclosure agreements have been executed between the CAP and the vendor companies (Complete Genomics, Life Technologies, and Illumina). The agreement for deliverables and support between CAP and the vendors are currently in process.

   - The NGS PT product will be the first proficiency product on the market for NGS. This is also well aligned with CAP’s Transformation goals of leadership in genomic medicine by creating
standards and proficiency test products in a disruptive technology area for the laboratory medicine community.

- The NGSWG have been able to form collaborative relationships with ACMG, AMP, CDC, NHGRI, NCBI, European Molecular Quality Network, and the New York State Department of Health to harmonize standards and guidelines for NGS for clinical testing. Representatives from some of these organizations have invited the NGSWG to participate in their workgroups or have attended or will attend upcoming NGSWG’s face-to-face meetings.

6. **POLICY ROUNDTABLE COMMITTEE (PRTC)**

   - **Policy Expert Breakfast.**

     The Policy Roundtable held a “policy breakfast” on its recent ACO white paper for DC-based health policy influencers and stakeholders. This breakfast was designed to allow an informal conversation with a relatively small group. Among the organizations represented at the breakfast were Premier Healthcare Alliance, National Quality Forum, NCQA, AcademyHealth, the Healthcare Leadership Council, and the American College of Radiology. We also had an attendee who is a prominent health services researcher at Georgetown University (not associated with the self-referral paper) and is a MedPAC Commissioner. CAP was represented by Dr. Richard Friedberg (PRTC Chair) and Dr. Donald Karcher (CAP’s ACO Learning Network Chair).

     The breakfast successfully raised awareness among these stakeholders of the role that pathologists can play in helping ACOs achieve their goals. We had an excellent discussion and received ideas for future research. In addition, there have been two direct outcomes from the event:

     - AcademyHealth, the pre-eminent organization for health services researchers, reached out to CAP to discuss ideas for future research ideas that they fund (together with the Robert Wood Johnson Foundation). They invited CAP and members of the PRTC ACO Workgroup to submit proposals for funded research and also identified health economists with the kind of expertise that we would want for an economic assessment of pathologist interventions in ACOs.

     - Premier Healthcare Alliance reached out to Advocacy to discuss issues related to coordinated care and pathology.

     The PRT expects to convene several policy breakfasts (or similarly structured events) in 2013. Some of these could support or raise awareness of PRT work, while others will be designed to give visibility of other TPO efforts that have policy implications (e.g., DIHIT’s upcoming white paper on the role of pathologists in the era of electronic health records).
Webinar for members.

- The first Policy Roundtable Webinar was presented on September 25, 2012. The topic of this webinar was “Thriving in an ACO: How Pathologists Can Confront Challenges and Maximize Opportunities”. The webinar was moderated by Dr. Friedberg and featured presentations by PRT Director, David Gross, who gave highlights of the ACO white paper, and Dr. David Scamurra, who was one of the pathologists whose experiences were cited in the white paper. Three hundred people were signed up for the webinar and ninety percent of the participants remained for the entire webinar. This was an effective vehicle for reaching out to members, exposing them to the PRT’s work, and allowing them to ask questions about the real-life implications of working in an ACO.

- The webinar also resulted in:
  - Five inquiries from members about joining the CAP ACO Network
  - Increased visibility for pathologists and for CAP via an article about Dr. Scamurra and the webinar in the October 18 issue of Health2 Resources’ electronic newsletter H2Resources: Accountable Care. This e-newsletter is distributed to professionals who are interested in Accountable Care.

- Health Affairs article. Policy Roundtable staff and Policy Roundtable Committee member Dr. James Crawford continue to work with Dr. Sam Caughron to develop a 3,000-5,000 word commentary piece on the role of pathologists in providing health care, both now and in the future, for the prominent health policy journal Health Affairs. We hope to have a draft in the next few weeks that can be shared with CAP leadership and CAP Communications staff to make sure that the main issues are consistent with those being put forth by the College in other venues (e.g., the Transformation).

- Organization of a Policy Compendium. Staff has developed a rough draft, and has coordinated with Governance, on a more organized and more user-friendly policy compendium. As part of this exercise, we also have identified gaps in policy (i.e., there are no policies on HIT or GME) or areas that may need re-assessment by the committees or councils that have jurisdiction over particular policies. We will continue to work closely with Governance as this project proceeds.

- Future research projects. The PRTC has developed a draft 2013 research agenda which will be presented for TPOS C approval in early December. The agenda was designed to mesh with the current Transformation strategy and the Promising Pathways work. Specific projects being proposed include:

  - Workforce/Graduate Medical Education. Develop policy research and analysis to assess the quantitative and qualitative characteristics of the necessary supply of pathologists entering the field, to provide the new knowledge and skills required now
and in the future, e.g. in the next 10-20 years. Key inputs to this analysis include the workforce model developed by Module 1 of the Case for Change; surveys of pathology programs; and qualitative analysis and discussions with ACP/PRODS, other pathology organizations, and the AAMC. We are coordinating with Advocacy and GMEC on this effort. (Chair: Dr. Stephen Black-Schaffer)

- **Quantifying Pathologist “Value-Added” in Coordinated Care.** Conduct policy research and analysis that demonstrates how specific pathologist interventions can help a coordinated care system to reduce costs and/or improve outcomes and quality of health care. Such research can be used to influence health system administrators, other providers, and policy makers about the critical value of pathologists as key members of the patient care team (see strategy (7) in A Strategy for Helping Transform Pathology: A Call for Action Among CAP Leadership. We will be coordinating with Advocacy on this project. (Chair: Dr. James Crawford)

- **Genomic Medicine.** The committee is considering writing a white paper on the issues related to Value Based Pricing of genetic tests, an approach which has been pushed by the Personalized Medicine Coalition but which CAP has opposed. The committee will also examine payment issues in more depth after release of the AMP White Paper on using the CPT to pay for molecular tests. We will be coordinating with Advocacy and PHC on this project. (The Economic Affairs Committee has been coordinating with Association of Molecular Pathology on this effort.)

- **Health Information Technology.** The Policy Round Table Committee expects that policy issues may emerge from DIHIT’s upcoming white paper on the role of the pathologist in the age of the electronic health record, and will revisit the issue once that paper has been released.
Realizing Our Vision

BACKGROUND:

Our primary metrics for success are extracted from the annual "House Effectiveness" and "Meeting Format" surveys completed by House Delegates, the CAP Board of Governors, and the CAP Leadership Staff.

Secondary metrics for success include: Meeting Registration and percentages of: Delegate Chairs Submitting Reports, CAP Councils/Committees seating Delegates, HOD members serving on CAP Councils/Committees and HOD Positions filled.

CONTENTS OF THIS SECTION:

• January 2013 Speaker Memo
• 2012 House of Delegates Report Card
• Dashboard Reports as of January 2013
House Colleagues,

Thanks to all of you who completed our House of Delegates (HOD) Annual Report Card.

My reading of your responses is that majority of you support both the direction in which the House Steering Committee is taking the House, and the format by which we conduct our biannual meetings. A number of you were unable to offer opinions on either. That tells me we need to do a better job of communicating to you precisely what we are trying to accomplish.

Below, I have bundled my responses in a manner that I hope will answer most of the questions your comments implied. Please let me know if I have missed anything.

**Strategy**

Understanding the direction in which we are steering the House requires you knowing our mission: we are the "voice of the membership." We apprise the Board of Governors as to how we feel they are doing meeting the needs of our 18,000+ members. There is no one but the HOD that performs this function.

Our strategy to achieve this mission required us to dismantle the anachronistic notion of the House as a "legislative body," even though that's what CAP bylaws state we are. We did this because those bylaws left out a crucial step: they include no provisions for enacting whatever legislation might emanate from the House. That was not an oversight. Framers of these bylaws appreciated that two policy-making arms in the same organization would be an operational nightmare. Indeed, participating in policy decisions that we ask our Governors to make blurs accountability and neutralizes the House’s ability to grade the Board on those decisions.

So for better than a half a century, thinking itself a legislative body the House churned out legislative resolutions that often disappeared in procedural vacuums. This of course engendered all sorts of ill feelings among Delegates and Governors, creating great distance between the House and the governing arm of the College. We set out to devise a strategy that reconnected the House and the College, a vision we’ve coined “One College.” The strategy we believe that defines our mission establishes the House not as a legislator, but rather a “customer.” As customers, we are in the best place to evaluate the services that the College provides us.

But a new strategy means new tactics, and I can understand why this change might not sit well with those who like the way things were; conducting reference committees, participating in open floor debates, and passing resolutions. However, we believe it is precisely these activities that landed us in the pickle we found the House 2 ½ years ago. So what’s changed?

**Raising Our Voices**

We communicate with the Board and with each other in several ways. The Speaker and Vice Speaker are voting members of the Board of Governors. Although as full Board members we cannot represent the House, we do relay your views.
Once a year, we ask you to bring to your Delegate Chairs, issues that you would like the Board to address. We post on our website, Governors’ responses to those issues. We urge Delegates to debate those responses. Certainly we are all aware of the shortcomings of the CAP website (the College’s commitment of millions of dollars to redo its information system will be the subject of a short update at the Spring HOD Meeting). Yet we know the site works because we read your comments on it. So do your Governors. We have asked every Governor to sign up for a site alert—you post a comment, they read it, and if appropriate, respond to it. Every one of you has a direct conduit to the CAP Board of Governors.

At our Spring HOD Meeting, we invite all candidates for CAP Governor and officer to an open session in which you have the opportunity to ask them how they, if elected, plan to address issues of importance to you.

And finally, we have our College Report Cards. Once a year, we post the grades that you give the Board on the job it’s doing to meet your needs. We share this report card with the Board.

These activities are the essence of “being the customer.” Our intention is that you will influence College policy by using all of this information—the Delegate Chair reports, the website debate, the Candidate Forum and the College Reports—to determine who you will choose to be your College leaders, and if you are fulfilling your responsibilities as Delegates, you will be taking this information back to your 18,000+ constituents so that they can make informed decisions.

Biannual Meetings

The primary purpose of our HOD meetings is to have our College leadership tell us what they are or plan to be doing to address issues of importance to us. At least twice a year we survey all of you to learn what those issues are. These presentations include time for us to question our College leaders about those activities.

These meetings are also vehicles, by which you can network with your peers, something you consistently tell us is important to you.

Several other items of interest to you:

- We will incorporate your requests to seat State Delegations together.
- We will begin researching electronic access at future meetings.
- CAP award presentations and College updates are provided at a joint session that is not exclusive to the House, but is shared with the Residents Forum and Board of Governors. Your attendance is encouraged by the HOD.
- All Governors attend HOD meetings.
- The College reimburses Delegates for their attendance

Action Groups

The work of the House is done between the biannual meetings. Most of the heavy lifting is done by Action Groups (AGs). We prefer AG’s rather than committees. Committees sometimes seem to labor endlessly regardless of output. Our AGs are given finite charges
and one year to produce their deliverables. Our HOD staff implements actionable AG recommendations. We reconstitute the membership of AGs whose projects require longer than a year to complete. Shuffling AG membership allows us to provide as many Delegates as possible opportunities to participate in House activities, which in turn adds fresh perspectives to the projects.

Recent AG activities yielding implementable actions include:

- Providing leadership pathways for Delegates.
- Involving State Societies in the HOD.
- Providing Delegate Chairs a greater role in House operations.
- Assimilating Residents and pathologists newly in practice into the HOD.

The activities, reports and progress of the Action Groups (“what’s going on”) are posted on our website.

Also posted on the site are the names of those who chair and serve these groups. These are your action groups. If you have something to contribute, by all means call or email the chairs or your colleagues serving on the AGs. It is our intention to offer every Delegate the opportunity to serve on an AG. If you would like your turn to be sooner rather than later, please contact Marci Zerante.

Other Survey Issues

- Monthly, the Council on Government and Professional Affairs provides us legislative updates which we post on our website. These updates cover the majority of issues you have articulated are important to you. As for the myriad of other information available from the College, there simply is not the time or manpower for the House staff to reproduce what the College is already doing elsewhere--and doing well--on College websites, emails, and webinars.
- Quarterly, the College posts updates on activities of CAP Councils and Committees. We will begin posting these in on our website in early 2013.
- I refer those of you who would like to be donors or recipients of information regarding issues challenging the practice of pathology to the College Peer to Peer Program. For more information, please contact Senior Specialist Nora Bowers.
The following report contains the House of Delegates (HOD) Performance Results from the December 2012 Survey. This information will be used as baseline metrics for evaluating the effectiveness of the House of Delegates, House of Delegates Leadership and House of Delegates Meetings.
## HOD Survey Results - Baseline Metrics

### Annual Report Card Response Rates:

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<tr>
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<th>2010</th>
<th>2011</th>
<th>2012</th>
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<tr>
<td>Board of Governors</td>
<td>56% (9 of 16)</td>
<td>69% (11 of 16)</td>
<td>79% (15 of 19)</td>
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<tr>
<td>Executive Leadership Team</td>
<td>43% (6 of 14)</td>
<td>36% (5 of 14)</td>
<td>50% (7 of 12)</td>
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<tr>
<td>House of Delegates</td>
<td>35% (86 of 249)</td>
<td>35% (97 of 277)</td>
<td>43% (135 of 315)</td>
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### Questions

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<td><strong>1. HOD Meeting Format</strong></td>
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<tr>
<td>* 1A. Joint Session with Residents Effective</td>
<td>3.95</td>
<td>4.15</td>
<td>4.13</td>
<td>4.00</td>
<td>4.27</td>
<td>4.08</td>
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<td>* 1B. Format allows HOD input to CAP leadership</td>
<td>3.89</td>
<td>3.85</td>
<td>4.02</td>
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<td>* 1C. Format was appropriate and encouraged participation</td>
<td>4.13</td>
<td>4.14</td>
<td>4.07</td>
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<td>* 1D. Meeting met stated objectives</td>
<td>3.73</td>
<td>4.24</td>
<td>4.22</td>
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<td>* 1E. Meeting purpose and objectives were clearly stated</td>
<td>3.71</td>
<td>4.25</td>
<td>4.27</td>
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<td><strong>2. HODSC Effectiveness</strong></td>
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<td>* 2A. I am well informed of College activities related to HOD, status</td>
<td>3.53</td>
<td>4.11</td>
<td>4.16</td>
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<td>and next steps</td>
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<td>* 2B. I am well informed of HOD activities, status and next steps</td>
<td>3.75</td>
<td>4.20</td>
<td>4.22</td>
<td>3.89</td>
<td>4.45</td>
<td>4.69</td>
<td>2.83</td>
<td>3.40</td>
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<td>* 2C. HODSC is performing to HOD/Leadership expectations</td>
<td>3.81</td>
<td>4.27</td>
<td>4.26</td>
<td>3.22</td>
<td>4.18</td>
<td>4.23</td>
<td>3.00</td>
<td>3.80</td>
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<td>* 2D. HOD Speaker is performing to HOD expectations</td>
<td>3.98</td>
<td>4.39</td>
<td>4.43</td>
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<td><strong>3. HOD as a Whole</strong></td>
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<tr>
<td>* 3A. Ample opportunities for Delegates to participate</td>
<td>3.78</td>
<td>3.89</td>
<td>3.97</td>
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<td>* 3B. CAP leadership is receptive to HOD opinions</td>
<td>3.27</td>
<td>3.80</td>
<td>3.95</td>
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<td>* 3C. HOD is an effective body and meets its obligations</td>
<td>3.44</td>
<td>3.87</td>
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<td>* 3D. HOD input instrumental in influencing policy</td>
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<td>3.22</td>
<td>3.82</td>
<td>4.08</td>
<td>2.67</td>
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<tr>
<td>* 3E. HOD functions well in articulating voice of membership</td>
<td></td>
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<td></td>
<td>3.11</td>
<td>3.73</td>
<td>3.85</td>
<td>2.67</td>
<td>3.60</td>
<td>3.57</td>
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5.0 = Strongly Agree  
4.0 = Agree  
3.0 = Neither Agree or Disagree  
2.0 = Disagree  
1.0 = Strongly Disagree  

* = Questions related to the effectiveness of HOD activities, status, and next steps.
HOD Meeting Format

The following are verbatim comments provided by HOD members to the following statement: Please list ideas or suggestions for improving the format of these meetings.

1. In the future it may be worthwhile implementing web based conferences to increase the frequency and attendance of such meetings. i.e. gotomeetings.com
2. Review issues from different practice setting perspectives and give examples of successes and possible best practices along with pitfalls
3. More "open mic" time to dialogue and discuss with presenters
4. Have Board of Governors represent current problems (ex, coding payment issues), goals, and lobbying activities especially where CAP is different from AMA).
5. I like it
6. A bit longer
7. No ideas from me. I could not attend the last meeting.
8. none
9. Consider allowing members to attend and vote electronically.
10. role of telepathology
11. My schedule does not permit attending a lot of these meetings. I suggest more opportunities for electronic participation on important and time sensitive issues.
12. In general, too much time spent on awards. I would like to have more time for candidates for office--not only governors but president, sec/treas, etc.
13. no comment
14. Consider allowing remote participation
15. tight control over meeting. better leadership in keeping discussion on topic shorter meeting
16. The meeting in general seems to be nothing more than a pep rally for the CAP, and not intended to generate anything meaningful, at least in my experience.
17. More time for members to speak at the microphone and make their points and opinions known on various issues is needed. There is a lot of passive presentation of information.
18. It may be helpful to sit with other delegates from your state.
19. Please keep the residents involved. It is one of the best parts of attending HOD.
20. How do we better involve other younger pathologists in practice?
21. Love the format
22. Opportunity to discuss issues from the floor remains an issue from my perspective. Agree with improvements, but do not feel needs best met by not having opportunity to have an open discussion. Also, the CAP leader reports can be read before hand with questions but do not need a presentation per se.
23. attendance by electronic methods should be explored, i.e. skype, off site downloads at medical society offices.
24. I like the current meeting formats. The current House Speaker is doing a great job. Thank you.
25. An effort should be made to seat states together.
26. More pre-meeting information should be disseminated
27. Delegations need to sit together so that WE can network - this is often our once twice a year chance to interact with each other! We want to interact with others as well, but there were people in my OWN delegation, as the Chair, I did not track down for the entire meeting, and others it took considerable time – away from other business - to track down.

28. None.

29. more interaction with other state delegates; I always enjoy meeting the residents.

30. Could the awards session be at the end of the day? It seems much high energy morning time is spent on formalities instead of "business".

31. The HOD meetings are often informative, but they are laced with too much bravado, kudos, and posturing. Most of the take-home messages are excellent and provocative. For instance, this past HOD meeting, during elections, when there was a write-in candidate for Serrgent at Arms, the current guy, Alfred Campbell, took his speech as a joke, talking about a turkey in every pot, and yet, he was elected anyway. If elections are a farce, we should not have them. That said, I am still trying to wrap my head around a meaningful meeting format, where information is both provided and received and members are encouraged to help move our field forward and not just behind the scenes.

32. keep up the great work

**HODSC Effectiveness**

The following are verbatim comments provided by HOD members to the following statement: *Please list ideas or suggestions for how the HODSC may better serve the needs of the House.*

1. Brief updates on issues, maybe one issue per month. Requests for input, practice specific suggestions, etc.
2. Doing an excellent job already.
3. I think the work groups reports/discussion was much better previously, got short changed this last meeting
4. none
5. none
6. Request electronic participation on important time-sensitive issues.
7. Is there a "report" from the HODSC outlining what they have done for the general house membership over the past session? If yes, sorry i missed it. If not, a brief report would be nice.
8. no comment
9. there should be some reimbursement for expenses of HOD members for travel/lodging to attend HOD mtgs
10. Communication can always be better. We need a better website.
11. send additional brief emails describing HODSC initiatives
12. Perhaps by providing materials to take back to our state societies.
13. Keep a monthly dialogue going with members of the HOD with a letter or emails, etc. We don't mind.
14. CAP needs to find better ways of keeping members informed of its many activities and successes
15. Dr Novis is awesome
16. e-mail synopsis by topic. time line report by topic.
17. The current HODSC is doing a great job.
18. The AG approach has been great. I feel we need to strengthen the next steps, i.e. make sure AG reports are acted upon in tangible ways, rather than rolling it into another AG.
19. None.
20. Can't say enough good things about Dave Novis. He is our fearless leader, and I've learned quite a bit from him. Best HOD Speaker ever.
21. There are many surveys about what members would like to see at the meeting. This is appreciated. However, action items are few and far between. Encouraged viewings of webinars are nice but not yet practically incorporated into a regular busy workday. The HOD needs to have a more focused mission.

The following are verbatim comments provided by HOD members to the following statement: Please list any ideas or suggestions you have for the HOD Steering Committee.

1. Periodic update on topics/projects with reminders for input since we all are overloaded and may need several requests or reminders for input. Repetition is part of the learning process?
2. none
3. none
4. Explain to us our purpose.
5. The speaker, vice-speaker, other could/should act as a liaison to the BOG for the House membership with interim reports on the BOG activities
6. no comment
7. pls find stronger ways and provide more practical tips to engage state path societies
8. as stated
9. N/A
10. great job!!!!
11. CAP/HOD team to strengthen state societies best practices, economical communication, etc
12. skype, local downloads of meetings, real time white board
13. Updates on CAP activities.
14. Consider revisiting the nomination process on how to become a delegate / alternate. This becomes more pertinent in larger states, but I (as an alternate) have attended every HOD meeting for the past 3 years, while a significant number of the actual delegates have missed many meetings (with some never having shown up in any!)
15. Wake up and engage the membership or step aside.
The following are verbatim comments provided by CAP Board of Governors and Executive Leadership Team to the following statement: Please list ideas or suggestions for how the HODSC may better serve the needs of the College.

1. See if a Board member would be willing to speak at HOD on a regular basis regarding Board activities? (In addition to normal Board interactions with HOD). Liz Wagar
2. Form groups to poll upcoming board issues much more cohesively. The candidate interviews are not a good use of HOD time as they have only 2 face to face meetings.
3. I have always believed that the HOD needs to be at the forefront of the transformation effort. Don't know whether the connection should come from HODSC or TPOS -- probably both.
4. Serve as spokespersons to advance the CAP agenda.
5. I am very pleased with the enthusiastic engagement of HOD members, much more so than in the past.
6. The CAP leadership staff periodically provide reports or responses to specific questions of the HOD. May simplified bullet point reports be provided to CAP XLT as to initiatives, outcomes and inquiries at least quarterly?
7. HODSC has been very much a Membership entity and I believe that it would be beneficial for all Executive staff to have a presentation on how the HODSC wants to interact with CAP and what areas it believes it could be a resource to tap into. Elizabeth

HOD as a Whole

The following are verbatim comments provided by HOD members to the following statement: Please list ideas or suggestions for how the HOD may better represent and convey the voice of the HOD.

1. Target specific members and practices on a rotating basis for input, reaction
2. continue workgroups with encouraged participation by all delegates on a rotating basis
3. An e newsletter.
4. none
5. A clearly defined mission will help. What are we trying to accomplish (as a House- action committees) and how are we trying to do it? What is the purpose of our biannual meetings?
6. I would like to see the HOD have more input into the "policy" decisions made by the college.
7. no comment
8. More participation from community hospital-based/private practice pathologists. CAP leadership, committees, HOD over-represented by pathologists from AMCs/tertiary care medical centers.
9. as stated
10. Since the board controls everything, these questions seem pointless
11. More time for us to talk.
12. N/A
13. Regional or state meetings a month or so before the HOD meetings might be helpful.
14. Be certain that key decisions/conclusions made at meetings are distributed to Governors, HODSC, HOD and CAP membership.
15. there is a focus on physical presence for participation. greater creativity will lead to greater participation.
16. Send out questions to be addressed in a survey in advance of the HOD by 3 wks, with reminders.
17. I am currently satisfied with HOD meetings
18. The HOD and SPS need to communicate better and work together.
19. More representation on committees.
20. Not sure about this, but in recent years, the message of "one House" has been better implemented. Would love to see more Board of Governors at the HOD meetings.
21. The Speaker of the HOD is extremely open to the thoughts and opinions of the HOD membership. However, it is unclear how that translates into any meaningful pursuit. Saying that members may get involved in action groups and that this is the way to have impact through the HOD would require that all members of the HOD should be involved in action group. For, without action, what is the purpose of an HOD? Personal interest? Not good enough. What are the impacts of individual action groups and how do we translate a successful action group effort into a strategic method for success of more languid groups.
22. more use of electronic media, blogs, wiki, etc

The following are verbatim comments provided by HOD members to the following statement: Please list ideas or suggestions for how the HODSC can create more opportunities for you to participate in HOD activities.

1. Targeted requests for input, especially in different phases of a project. Draft reports with requests for input?
2. see above
3. none
4. see of action groups will allow more participation of the HOD members
5. Allowing the HOD to play a role. Work has been shifted to AC and we are passive recipients of info.
6. The HOD should be made aware of what happens at each BOG meeting...minutes?
7. no comment
8. maybe HOD members should be divided into groups and given specific tasks, such as a topic to research.
9. Decrease cost of meetings, hold regional meetings quarterly with 1 annual meeting, subsidize/encourage state delegate meetings.
10. pls engage more members with indiv emails as to where there are specific areas where help is needed.
11. as stated
12. N/A
13. Keep us abreast of evolving needs to address representatives of Congress or regulatory bodies on issues facing pathologists.
14. Periodic webinars or conf calls with delegates to address on going or new issues, between the face to face meetings.
15. Make a list of opportunities currently available for Delegates, identify activities without HOD representation and do gap analysis.

16. see above.

17. Roundtables

18. I am currently satisfied with opportunities to participate in HOD activities

19. I think more delegates need to be involved in the real work of the HOD that occurs between meetings.

   Its not enough to simply show up.

20. remote participation in meetings

21. Action Committees are great, I've been a part of one, and would love to contribute more.

The following are verbatim comments provided by CAP Board of Governors to the following statement:  
*Please list specific issues in which HOD input influenced CAP policy formation or implementation.*

1. Recognition of the importance of regional pathology societies.

2. Tcp


4. Advocacy and Education
HOD Dashboard Key

1. HOD – House of Delegates
2. BOG – Board of Governors
3. AG – Action Group
4. Cmtes – Committees
5. C/C’s – Councils and Committees
HOD Meeting Format

As of January 2013

- 2010: 3.95
- 2011: 4.15
- 2012: 4.13
HODSC Effectiveness

As of January 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>HOD</th>
<th>BOG</th>
<th>Executive Leadership Team</th>
</tr>
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<tr>
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<td>3.8</td>
<td>3.56</td>
<td>2.92</td>
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<tr>
<td>2011</td>
<td>4.24</td>
<td>4.32</td>
<td>3.6</td>
</tr>
<tr>
<td>2012</td>
<td>4.27</td>
<td>4.46</td>
<td>3.43</td>
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</tbody>
</table>

- Blue: HOD
- Red: BOG
- Green: Executive Leadership Team
HOD As a Whole

As of January 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>HOD</th>
<th>BOG</th>
<th>Executive Leadership Team</th>
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<tbody>
<tr>
<td>2010</td>
<td>3.17</td>
<td>2.67</td>
<td>3.55</td>
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<tr>
<td>2011</td>
<td>3.85</td>
<td>3.4</td>
<td>3.78</td>
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<tr>
<td>2012</td>
<td>3.94</td>
<td>3.97</td>
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Meeting Registration
As of January 2013

<table>
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<tr>
<th>Location</th>
<th>Spring 2008</th>
<th>Spring 2009</th>
<th>Fall 2009</th>
<th>Spring 2010</th>
<th>Fall 2010</th>
<th>Spring 2011</th>
<th>Fall 2011</th>
<th>Spring 2012</th>
<th>Fall 2012</th>
<th>Spring 2013</th>
<th>Fall 2013</th>
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<tbody>
<tr>
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<td>Baltimore</td>
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% of CAP Councils/Cmtes with Delegates
As of January 2013

- 2011: 67%
- 2012: 58%
- 2013: 63%

[Bar chart showing the percentage of CAP Councils/Cmtes with delegates from 2011 to 2013.]
% of HOD Serving on CAP Councils/Cmtes

As of January 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>HOD</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>48%</td>
</tr>
<tr>
<td>2012</td>
<td>52%</td>
</tr>
<tr>
<td>2013</td>
<td>66%</td>
</tr>
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</table>
HOD Positions Filled
As of January 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Delegates</th>
<th>Alternates</th>
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<tr>
<td>2008</td>
<td>77%</td>
<td>11%</td>
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<tr>
<td>2009</td>
<td>78%</td>
<td>13%</td>
</tr>
<tr>
<td>2010</td>
<td>80%</td>
<td>18%</td>
</tr>
<tr>
<td>2011</td>
<td>92%</td>
<td>31%</td>
</tr>
<tr>
<td>2012</td>
<td>96%</td>
<td>44%</td>
</tr>
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Candidate Forum ‘13

BACKGROUND:

The three-year terms of one third of the CAP Governors and officers expire yearly. This staggering prevents the entire CAP Board of Governors from turning over in any given year. The Spring ’12 House of Delegates meeting hosted the first of what we hope will be an annual Candidate Forum. This Forum is the only live public appearance at which candidates running for CAP offices can present themselves to House Delegates. In this 90-minute open microphone session you will have the opportunity to ask candidates their opinions on issues of importance to you.

The Candidate Forum includes all candidates who have declared their intent to run for office as of February 15, 2013. Additional candidates may enter the election through July 14, 2013.

CAP President Elect Candidates:

Richard C. Friedberg, MD, PhD, FCAP

CAP Governor Candidates:

David L. Booker, MD, FCAP
Richard R. Gomez, MD, FCAP
Bharati Suketu Jhaveri, MD, FCAP
Emily E. Volk, MD, FCAP

CONTENTS OF THIS SECTION:

• None
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Providing Value

BACKGROUND:

Prior to each meeting we survey delegates asking what you want to talk about at the next meeting. Your survey responses are what drive HOD meeting agendas.

The Spring '13 Meeting Topics Survey results are available on the HOD website.

This section contains pre-read information for the afternoon segments.

CONTENTS OF THIS SECTION:

• Providers Form 106 New Accountable Care Organizations
• Helping Your Practice Address Emerging Health Care Payment Systems
• Controlling Our Economic Destiny – The New Logic
• Practice Information Form
Doctors and health care providers have formed 106 new Accountable Care Organizations (ACOs) in Medicare, ensuring as many as 4 million Medicare beneficiaries now have access to high-quality, coordinated care across the United States, Health and Human Services (HHS) Secretary Kathleen Sebelius announced today.

Doctors and health care providers can establish ACOs in order to work together to provide higher-quality care to their patients. Since passage of the Affordable Care Act, more than 250 Accountable Care Organizations have been established. Beneficiaries using ACOs always have the freedom to choose doctors inside or outside of the ACO. ACOs share with Medicare any savings generated from lowering the growth in health care costs, while meeting standards for quality of care.

"Accountable Care Organizations save money for Medicare and deliver higher-quality care to people with Medicare," Secretary Sebelius said. "Thanks to the Affordable Care Act, more doctors and hospitals are working together to give people with Medicare the high-quality care they expect and deserve."

ACOs must meet quality standards to ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe, and timely. The Centers for Medicare & Medicaid Services (CMS) has established 33 quality measures on care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care. Federal savings from this initiative could be up to $940 million over four years.

The new ACOs include a diverse cross-section of physician practices across the country. Roughly half of all ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately 20 percent of ACOs include community health centers, rural health clinics and critical access hospitals that serve low-
income and rural communities.

The group announced today also includes 15 Advance Payment Model ACOs, physician-based or rural providers who would benefit from greater access to capital to invest in staff, electronic health record systems, or other infrastructure required to improve care coordination. Medicare will recoup advance payments over time through future shared savings. In addition to these ACOs, last year CMS launched the Pioneer ACO program for large provider groups able to take greater financial responsibility for the costs and care of their patients over time. In total, Medicare’s ACO partners will serve more than 4 million beneficiaries nationwide.

Also today HHS issued a new report showing Affordable Care Act provisions are already having a substantial effect on reducing the growth rate of Medicare spending. Growth in Medicare spending per beneficiary hit historic lows during the 2010 to 2012 period, according to the report. Projections by both the Office of the Actuary at CMS and by the Congressional Budget Office estimate that Medicare spending per beneficiary will grow at approximately the rate of growth of the economy for the next decade, breaking a decades-old pattern of spending growth outstripping economic growth.

For more information on the HHS issue brief, “Growth in Medicare Spending per Beneficiary Continues to Hit Historic Lows,” visit:

Additional information about the Advance Payment Model is available at

The next application period for organizations that wish to participate in the Shared Savings Program beginning in January 2014 is summer 2013. More information about the Shared Savings Program is available at

For a list of the 106 new ACOs announced today, visit:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html.
To read the blog by Jonathan Blum, Acting Principal Deputy Administrator and Director, Center for Medicare, visit: http://blog.cms.gov/
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Helping your practice address emerging health care payment systems

**Background:**

The CAP is moving forward to help pathologists control their professional and economic destinies. In this session the CAP will present initial tools for helping practices adapt to emerging payments systems and ask for your input on current practice organizations, examples of practices addressing key issues, and identifying and prioritizing.

**Preparation:**

1. Please read the enclosed *Controlling Our Economic Destiny - The New Logic* chapter from the Promising Practice Pathways™ report. The full report is available at [YourPathYourChoice.org](http://YourPathYourChoice.org)
2. Please fill out the enclosed practice information form. Electronic version of form available on the [HOD Collaboration Space](http://HOD.Collaboration.Space)
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Controlling Our Economic Destiny – The New Logic
CONTROLLING OUR ECONOMIC DESTINY – THE NEW LOGIC

We are forging these new practice pathways to gain control of our professional and economic destiny during the health care market upheaval of the next decade or so.

Health care is in the midst of turbulent times, and many traditional paradigms are being replaced and even inverted. Three of the most significant shifts involve the fundamentals of medical treatment, clinical information, and health care payment.

Three Turbulent Dynamics
First, treatment approaches are moving from empirical and population-based drug selection to patient test result-based selection. In other words, the individualized medicine era is changing how doctors prescribe, the role of diagnostics, and pharmaceutical drug development – and this is just the beginning.

The "omics" engines are creating market and practice inversions in many areas. Pharmaceutical companies have flipped from seeking "blockbuster" mass market drugs to "targeted therapies" individualized for particular cohorts, and typically accompanied by diagnostic tests.

The individualized medicine "inversion" of most interest to us is the relative power flips occurring between therapeutics and diagnostics. The importance of testing is escalating relative to therapeutics as test results move beyond the diagnosis and into treatment decisions. Molecular and genomic testing increasingly determines the most appropriate treatment for an individual, and many project that it will be designing optimal therapeutic cocktails. The rising significance of diagnostic testing has given rise to the moniker, "the golden era of diagnostics."

The second disruptive dynamic is the clinical information complexity crisis. A September 2012 report¹ from the Institute of Medicine analyzed the reasons why our health care system has been so slow to improve its performance. "The committee identified two reasons for the above problems that

grow more urgent every year. One is the increasingly unmanageable complexity of the science of health care. During the past half-century, there has been an explosion of biomedical and clinical knowledge, with even more dazzling clinical capabilities just over the horizon. However, the systems by which health care providers are trained, deployed, paid, and updated cannot usefully digest this deluge of information.”

Simply put, clinicians can no longer effectively cognitively process the ever growing mass of medical content being created every year, month, and week. The content overload issue is not an academic one. This information includes therapeutics, intervention guidelines, and diagnostic testing that directly impact care.

Moreover, this lopsided ratio will be amplified by 1) the projected shortages in a number of physician specialties, most disturbingly primary care and oncology and 2) greater service demand from the aging population. This adds up to a desperate need for a new way to manage clinical knowledge.

The answer, of course, is information technology services and informatics tools that deliver knowledge services. But computers don’t work without humans supplying content expertise. Enter pathologists – providers of expert diagnostic testing knowledge services to clinicians.

The final, critical turbulent force is inverting the central health care payment model from the top line to the bottom line. The traditional fee for service structure that incents more services is being replaced with “value-based” payment programs that compensate based on lowering costs and improving quality. This has providers and health systems scrambling to rearrange their business strategies and service models.

For the financial futures of some providers and health care sectors, these changes do not bode well. Their ability to generate value through improving quality outcomes and lowering avoidable costs may be limited, and/or high historical profit margins may make them easy targets for cost cutting.

There will be many winners and losers as profit pools shift in the turbulence of policy, business, and scientific change.

Pathologists can and should be among the winners, as individualized medicine is central to value-based health care and diagnostic knowledge specialists are needed to optimize outcomes and costs. But we won’t succeed in these new roles by applying “yesterday’s logic,” as Peter Drucker, “the man who invented management,” warns us.

**The New Logic**
The emerging logic formulated by these turbulent forces is our guide to entering a fascinating and successful new period in pathology and laboratory medicine.
This new logic can lead us to control our economic destiny, so grappling with these new rules seems the rational thing to do.

**Our new logic distills to this:**

1) **Test result reporting is a cost-cutting target.**

Our current, primary professional services – reporting test results – are prime targets for cost-cutting by payers and providers, as many view diagnostic testing to 1) not be very differentiated (i.e., be commoditized), and 2) be over-utilized. Furthermore, the degree to which the health care budget will need to be cut in the next few years means the pressures to find savings will be immense.

2) **Delivering services with measurable clinical value is going to be the only way to control our economic destiny.**

Since the health care market will reward only those services and interventions that create value (i.e., improve quality while maintaining or lowering costs), the only way we can compensate for the decline in payment for our traditional services is to ensure that we deliver services that directly create measurable clinical value. Services that generate value, in other words, are the key to controlling our economic destiny. Further, we must ensure that we are among the few providers who can deliver these value-generating services, in order to own the results and our share of the pie.

3) **We won’t generate very much value relative to our colleagues by focusing our value improvements on the tests themselves.**

Since our new compensation will be based on the value these services create, and diagnostic testing only represents 3 percent to 5 percent of health care spending, if we focus our value economics on improving the quality and lowering the costs of the tests themselves, the amount of financial value we will be able to create relative to other health care services will be very limited (e.g., 3 percent to 5 percent). This also implies that the value return we’ll deliver to ourselves and the system from lowering the volume of tests – i.e., test utilization – is relatively small, unless that utilization impacts downstream clinical costs.

1http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf
4) Value generation requires either improving traditional services or introducing new ones.

Creating clinical value inherently entails doing something differently – that is the only way to drive a change in quality and costs. Thus, in order to deliver services that generate value, we must either 1) improve the value of the traditional services themselves or 2) introduce new types of value-generating services.

5) Introducing new types of services will be the greater generator of value.

We determined in #3 above that improving the value of our traditional “test results services” could capture only very limited relative value, given its low share of total spending. Therefore, if we want to succeed in the new health care model by generating significant value, we turn to 2) introduce new types of value-generating services.

6) The most potent generators of value are services that directly change physician decisions, especially treatment decisions.

Physician decision making and/or the guidelines they follow are among the core levers that determine health care resource consumption and clinical outcomes, and hence, value. Thus, the value of our new services will be proportional to the degree we impact these levers.

7) We have a significant opportunity, with potent value generation potential, in providing pathology knowledge services to clinicians that address the unmanageable complexity of diagnostic testing information.

This opportunity is attractive in all respects –

a) There is a substantial need for these services, as identified by the Institute of Medicine, medical knowledge has far surpassed clinicians’ ability to manage or apply it clinically, and they specifically cite genetic testing as an example. Their report states, “Diagnostic and treatment options are expanding and changing at an accelerating rate, placing new stresses on clinicians and patients, as well as potentially impacting the effectiveness and efficiency of care delivery … One notable example of this complexity is advances in genetics, which offer unprecedented opportunities for personalized treatments but add to the already expansive array of clinical considerations for patients and providers.”

b) These services are potent value generators because ordering the right diagnostic tests, interpreting the results correctly, and linking these results to treatment recommendations impacts clinical outcomes, interventions, and hence costs.

c) We can translate a wide range of advanced knowledge in specialty areas directly into market value – this type of knowledge service is the antithesis of a commodity, and is highly protected from a competitive perspective.

d) Delivery of these services is facilitated by the emerging ubiquity of information technology and mobile/cloud platforms.

8) Individualized medicine offers another major, and long-lasting, source of value-generating services.

The information and technological complexity of individualized medicine testing requires mastery by a dedicated medical specialty area, which should be pathology.

As sequencing and other “omics” evolve, this field will further surpass clinicians’ abilities to implement the results in clinical care – creating demand for services that directly guide clinician decisions regarding how to use these new tests.

The value creation potential here is enormous – for in increasing number of conditions, substituting individualized therapeutic treatment for empirical treatment can improve outcomes and reduce both inpatient and ambulatory costs significantly.

9) We must establish our clinical value business case in order to realize these opportunities.

“Acting with today’s logic” means realizing that the value-based payment is not determined according to a fee schedule, but through measurable results of changes in quality and costs. Our compensation will be established based on negotiated agreements with providers and payments, and we will be making a business case quantifying, with evidence, the value our services generate.

10) We must act with urgency.

“Acting with today’s logic” means realizing that we need to change our image with other providers before our roles and hence fates are sealed in new value-based models like ACOs and oncology bundled care programs. Right now there is sufficient fluidity that providers all have an opportunity to formulate their own service models for delivering value, and hence their share of value com-
Compensation. This window is limited, as these models will become established and the opportunities to redefine roles will diminish. We must redefine our value proposition from that of delivering test results that many see as a commodity or cost center to that of providing valuable knowledge services that impact clinician decision making.

All providers, including non-physicians, are seeking to establish their value and share of the “pie” as the new value-based payment model gets implemented. We are not the only ones who can provide some of these services. In fact, new types of entrants from other sectors have already launched businesses that offer services in individualized medicine diagnostics, for example. If we want to be the experts that supply knowledge services to clinicians, we need to move forward soon.

**Controlling Your Economic Destiny**

The value-based opportunities created by these turbulent dynamics, and realizable through the new logic, enable our profession to control its future in ways not possible for many years.

For most of us, our economics have been dictated by diagnostic testing fee schedules and payer contracts that are largely out of our control. The pricing assigned to these tests has not been based on the value they bring, what the market would assign in terms of value, or even their cost-effectiveness, as is the case with other medical products, such as medical devices and pharmaceuticals. Rather, pricing has been basically assigned or adjusted based on test costs.

This model has naturally led to competition based on either lowering the cost of tests or value-added services to physicians. All of this, in turn, has made it difficult to escape being perceived as a commoditized cost center.

The value-based market and its new logic can change all of that. The combination of novel types of services and an “evidenced-based” manner of payment empowers us to use our intellect, skills, training, creativity and technologies to shape our own professional roles and revenues.

These services bring us right to the point of care as we utilize our diagnostic expertise to guide, and even make, clinical decisions in partnership with our physician colleagues.

These are not commodity services, and we will not be seen as a cost center. These are knowledge services that impact outcomes and costs directly, and will thus be compensated as such.

For example, we can identify problem cost areas within an ACO that are due to high variability in the time to the correct diagnosis and thus correct treatment. By introducing a program that includes a diagnostic testing service and series of tools that guide test ordering and result interpretation, we can directly impact care by avoiding
errors, improving outcomes, and lowering costs.

There are limits, of course. Fee-for-service payments for diagnostic testing are not completely disappearing any time soon. However, Medicare may launch bundled payments for oncology within the next five years that include diagnostic testing – that would change the game. Moreover, the value-based, new logic opportunities offer us an additional source of compensation over and above the fee schedule payments for the testing itself.

Many of us will be in employment situations, so our economic destinies are clearly differently defined. However, our variable compensation and the trajectories of our careers can certainly be changed by these opportunities if we seek them.

The transition from old to new economic logic, which includes deciding what mix of traditional diagnostic testing services versus new value-generating services to provide, will not be easy – that’s why it’s called turbulence. Strategic planning will be needed, as you’ll read in the chapters ahead.

We are very optimistic, though, because our economic analyses show that implementing even a sampling of these knowledge service programs can generate substantial value for an ACO or hospital system.

Specifically, we conducted an analysis using the Prometheus Payment model, which was recently adopted by Medicare as the engine behind their bundling programs. The Prometheus model identifies and quantifies potentially avoidable costs, called “PACs,” that are recognized as the result of “care defects” – problems necessitating clinical interventions that are under the professionals’ control and that, with the best professional standards, could have been avoided. PACs include, for example, all types of adverse events, such as hospitalizations for patients with uncontrolled diabetes, surgical site infections, and 30-day hospital readmissions.

The results of our modeling analysis on a Prometheus PAC database from a large, commercially insured population showed we could reduce the PAC costs allocated to providers by Prometheus by 30 percent. The pathology “knowledge service” interventions that generated this value included molecular and pharmacogenetic testing to guide therapeutics, quality control programs for point of care testing, and clinical decision support tools, to name a few.

In a bundled payment program or ACO this would be a substantial contri-

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3Developed by the Healthcare Incentives Improvement Institute (HCI3) – see http://www.hci3.org/what_is_prometheus

bution to value delivery. Reduction in PAC costs is the leading determinant of providers’ profit margins in the Prometheus bundled payment system.

Other economic modeling studies of the market opportunities offered by particular “practice pathway” models, as will be described in this report, suggest that the value-based revenues that can be earned would more than compensate for projected declines in fee-for-service revenues due to reimbursement cuts. Of course, these are only models that are, by necessity, built on assumptions and projections that are uncertain.

We do have choices. We can stick with the old logic and continue down our current path, which perhaps seems less risky. However, this path virtually ensures our economic future will not be in our control, as we will continue to be at the whim of government and private payers’ decisions about fee schedule pricing. The vast majority of analysts project declining revenues for traditional diagnostic testing over the next decade.

Moreover, we’ll have to contend with the new dynamic of sudden and large market shifts in lab and diagnostic testing contracts brought about by ACOs and hospital physician practice acquisitions. With little to differentiate ourselves when these providers are looking through a value and cost lens, we will likely be caught in the race to the bottom in a low-cost bidding game.

The new path certainly has risks, but it offers control, freedoms, and the opportunity to be valued based on our expertise and the clinical care we provide, rather than the costs of the tests we perform – as pathologists once were.

The new path’s freedoms are the key to control of our economic destiny, and they are several. The new path and logic provide:

- The freedom to choose from and switch between a variety of service models – including different types of clients, different types of services, and different types of payment models.

- The freedom to develop specialized expertise in new areas of clinical care that leverage our pathology and lab medicine knowledge.

- The freedom to innovate new solutions for any “care gap” for which diagnostic testing might improve performance, and be compensated for the results.

- The freedom to pursue these opportunities in any practice setting – community practice, employed pathologist, academic medical center, reference lab, etc. – because the value-based market will be ubiquitous.

One final consideration in making our choice regarding which path to choose concerns our responsibility to future generations. The turbulence and health care market reinvention that
we are living through happens rarely. Further, the type of golden opportunity being presented to pathology and lab medicine is unprecedented. Future generations likely will live with the die we cast now. Not only do we have a new economic control over our own destiny available to us, but we have the chance to reshape our profession for generations to come.
Practice Information

CAP Member Number:

Your Name:

Your Email:

Primary Practice Name (the organization on your primary pathologist paycheck):

Which of the following best describes your primary laboratory or practice setting?

- Academic Medical Center (with an ACGME residents program)
- For Profit Hospital (non-academic)
- Not for Profit Hospital (non-academic)
- Pathologist Owned Laboratory
- Corporate Reference Laboratory
- Niche Sub-Specialty Reference Laboratory
- Physician Office Laboratory (non-pathologist owned)
- Non-hospital lab of Military/Federal Government
- Other, please specify:________

Practice type:
- Path owned group,
- Academic practice plan
- Hospital employees
- Stand-alone laboratory employee
- Other: (Please specify:) ______________________________

Number of pathologists at my primary practice including all locations

For Academic Practice - Number of Residents:

Head of Practice Name:

Head of Practice Email:

Head of Practice Member Number:
To whom practice information surveys should be sent.

Practice Management Contact:

Practice Management Email:

Current challenges:

Recent successes:

Is your practice interested in participating in CAP 100?

Please list the other pathologists in your practice:

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Resources and Directories

Items previously found in this section are now located on the HOD Topic Center.

Visit us at...

cap.org\hod
Have a Smart Phone?

Scan the QR code for direct access to the HOD Website
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Reimbursement Form

BACKGROUND:

HOD Members who attend one meeting in the calendar year are eligible for up to $100 in reimbursed expenses. HOD Members who attend two meetings in the calendar year are eligible for a total of up to $300 in reimbursed expenses. Receipts must accompany the reimbursement form for the amount the member is claiming.

CONTENTS OF THIS SECTION:

- Member reimbursement form
This page is intentionally left blank.
Please complete demographic and travel related information below.

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**Reason for Travel:** House of Delegates Meeting

**Date(s) of Travel**

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**Auto**

1. Personal Auto (Enter miles in line 29 below) $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00

**# of Miles**

| 1 | 0.50 |

**TOTAL** $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00

**Total Expenses Incurred** $0.00

**Net Amount Reimbursable**

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**House of Delegates Members are eligible for up to $100 reimbursement for attending one meeting per calendar year and up to $300 total for attending two meetings per calendar year. Receipts must be submitted for all expenses.**

I hereby certify that the above expenses were incurred by me while on official business for the College of American Pathologists and that reimbursement is due me.

Signed

Date

I wish to donate my reimbursement to the CAP Foundation. (please initial on the line to the right)

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**For Office Use Only:**

**Approved**

Date

Please return form and receipts via fax to Marci Zerante at 847-832-8656.
Save the date for these CAP Events!

CAP Policy Conference
May 6 – 8, 2013
Fairmont Washington, DC
Washington, DC

CAP ‘13
October 12, 2013
THE Pathologists’ Meeting
Orlando, FL