



2007 Annual AMA-HOD Disposition of Actions

The AMA House of Delegates (HOD) convened June 23-27 in Chicago for its 2007 Annual Meeting. Over 300 policy items were considered by the House and a variety of timely educational sessions were conducted. (Visit the AMA Web site, www.ama-assn.org, for more information.)

The AMA Minority Affairs Consortium (MAC) Governing Council took an active role in this process. It authored three resolutions (Res. 115, 221, and 722) as well as testified on many key issues before the HOD, including those listed below with their final actions. For more information, please contact Wilda Knox at (312) 464-5529 or wilda.knox@ama-assn.org.

Please note that the following is a preliminary report of actions taken by the House of Delegates at its 2007 Annual Meeting and should not be considered final.

RPT/ RES	TITLE	SUMMARY / COMMENTS	OUTCOME
002	HIV Testing	<p>This resolution creates new AMA policy that requests that the AMA endorse routine screening or testing for HIV, as deemed appropriate by the attending physician, for individuals on admission to the hospital or upon visiting the emergency room or doctor's office; that this testing be a voluntary program; that the HIV screening permission be incorporated into general health care consent forms; that prevention counseling should not be a requirement for this testing program; and that when tests are positive, appropriate public health measures be instituted for surveillance, prevention of transmission, and dissemination of the virus.</p> <p>Testimony generally supported this resolution, but it was noted that the first resolve should be amended to specify that the new policy should apply specifically to HIV screening and testing. The Reference Committee believes this clarification is appropriate.</p>	<p>RESOLUTION 2 -- HIV TESTING</p> <p>RECOMMENDATION A: That the first resolve of Resolution 2 be <u>amended by insertion on line 12</u> to read as follows:</p> <p>RESOLVED, That our American Medical Association endorse routine <u>HIV</u> screening/testing for individuals on admission to the hospital, visit to the emergency room or doctor's office as deemed appropriate by the attending physician (New HOD Policy); and be it further</p> <p>RECOMMENDATION B: That Resolution 2 be <u>adopted as amended</u>.</p> <p>HOD ACTION: Resolution 2 <u>adopted as amended</u>.</p>

			<u>RESOLVED</u> , That our AMA adopt policy that when positive HIV patients are identified, appropriate linkage to HIV care be established.
CEJA 6	Physician Objection to Treatment and Individual Patient Discrimination (Resolution 5, A-06)	<p>This report follows Resolution 5 (A-06), “Physician Objection to Treatment and Individual Patient Discrimination,” by clarifying the grounds upon which physicians can conscientiously object to the performance of interventions that contravene their religious or moral beliefs, or can refuse to accept patients who desire such intervention. Following this analysis, the report concludes that physicians may ethically exercise their right of conscientious objection in non-emergency situations. However, when refusing to provide treatment on the basis of personal conscience, physicians must respect their duties to patients by providing them with a referral to another physician or health care facility in most circumstances. The report reaffirms existing AMA ethics policy.</p> <p>Testimony regarding this report was generally positive. Concerns raised in testimony were appropriately addressed by subsequent testimony. The Reference Committee agrees that a conscientious objection should, under most circumstances, be accompanied by a referral to another physician or health care facility, and recommends adoption.</p>	<p>RECOMMENDATION: That the recommendations in Council on Ethical and Judicial Affairs Report 6 be <u>adopted</u> and that the remainder of the report be <u>filed</u>.</p> <p>HOD ACTION: Council on Ethical and Judicial Affairs Report 6 <u>adopted</u> and remainder of report <u>filed</u>.</p>
112	Emergency Room Indigent Health Care Reimbursement for Physicians	RESOLVED, That our American Medical Association aggressively work with Congress, state legislatures, hospital associations, and physicians who are required by hospitals to cover hospital emergency services to advocate compensation of physicians for such services or sharing in the compensation for emergency services being provided in emergency departments and subsequent in-hospital care. (Directive to Take Action)	HOD Action: Placed on the reaffirmation calendar.
115	Assessing the Health Care Proposals of the US Presidential Candidates	Resolution 115 asks that our AMA (1) request details of the health care proposals of every declared Democratic and Republican candidate for US President in 2008; (2) evaluate the health care proposals of all candidates for US President, specifically on how they align with our AMA's strategic priorities and our advocacy to reduce health care disparities; and (3) report back on this issue at	<p>RECOMMENDATION: The Reference Committee recommends that Resolution 115 and Resolution 139 be <u>referred for decision</u>.</p> <p>HOD ACTION: Resolutions 115 and 139 <u>referred</u></p>

		<p>the 2007 Interim Meeting.</p> <p>Resolution 139 asks that: (1) our AMA request details of the health care proposals of every declared candidate for US President; and (2) summarize the health care proposals of all candidates for US President in a standardized format beginning at the 2007 Interim Meeting.</p> <p>Providing details of the health care proposals of declared presidential candidates was strongly supported as a valuable member benefit. Testimony brought up various suggestions, such as considering the removal of the words Democrat and Republican in Resolution 115 and acknowledging that the proposals will change, so the resulting product would need to be updated often. In addition, concerns were raised that the AMA must remain politically neutral in reporting candidate proposals so as not to appear to endorse one candidate over another. It was noted that the request to “evaluate” the proposals and declare how they align with the AMA may produce an unintended bias. Given the amount of issues raised and the highly sensitive political nature of the requests contained in these resolutions, the Reference Committee concurs with a suggestion for referral for decision.</p>	<p><u>for decision.</u></p>
117	Improved Coverage Options for the State Children's Health Insurance Program (SCHIP)	<p>Supportive testimony was heard on Resolution 118. The sponsors clarified that the meaning and intent of “performance based financial assistance” is to ensure that states receive specific funding to target enrollment of eligible children which in turn provides financing to ensure that physicians receive adequate payment. Testimony stressed the importance in targeted funding for SCHIP enrollment outreach and the ability to coordinate enrollment information with other public programs. Given the overwhelming support, the Reference Committee recommends adoption.</p> <p>Resolution 117 asks that our AMA: (1) strongly support State Children's Health Insurance Program (SCHIP) reauthorization and lobby toward this end; (2) lobby Congress to allow states to use SCHIP funds to augment employer-based coverage; (3) lobby Congress to allow states to explicitly use SCHIP funding to cover</p>	<p>RECOMMENDATION A: The Reference Committee recommends that the fourth resolve of Resolution 117, be <u>amended by insertion</u> to read as follows:</p> <p>RESOLVED, That our AMA lobby Congress to allow states the flexibility to cover all <u>eligible</u> children residing in the United States and pregnant women through the SCHIP program without a mandatory waiting period. (Directive to Take Action)</p> <p>RECOMMENDATION B: The Reference Committee recommends that Resolution 117 be <u>adopted as amended.</u></p>

		<p>eligible pregnant women; and (4) lobby Congress to allow states the flexibility to cover all children residing in the United States and pregnant women through the SCHIP program without a mandatory waiting period.</p> <p>The Reference Committee heard strong support for Resolution 117. In the fourth Resolve, the sponsors requested the addition of the word “eligible” as the original intention was not to cover all US children, but rather all eligible children.</p> <p>The request to lobby Congress to allow states to use SCHIP funds to augment employer-based coverage as a solution to employers dropping coverage was supported. Testimony also highlighted the importance of using SCHIP funding for prenatal care, even though some states are currently extending such coverage through this program. In addition, testimony stressed eliminating the mandatory waiting period, which includes the current barrier of federal Medicaid and SCHIP immigrant eligibility restrictions which deem legal immigrants, including children, ineligible for federally-matched Medicaid and SCHIP coverage during their first five years of residence in the US. The Reference Committee concurs with using SCHIP funding for these purposes and therefore, recommends adoption as amended.</p>	<p>HOD ACTION: Resolution 117 <u>adopted as amended.</u></p>
118	Expanding Enrollment for the State Children's Health Insurance Program	<p>Resolution 118 asks that our AMA: (1) strongly support the State Children's Health Insurance Program (SCHIP) reauthorization and lobby toward this end; (2) lobby Congress to provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through SCHIP through an enhanced federal match; (3) urge Congress to provide targeted funding for SCHIP enrollment outreach; and (4) support the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage.</p> <p>Supportive testimony was heard on Resolution 118. The sponsors</p>	<p>HOD ACTION: Resolution 118 <u>adopted.</u></p>

		clarified that the meaning and intent of “performance based financial assistance” is to ensure that states receive specific funding to target enrollment of eligible children which in turn provides financing to ensure that physicians receive adequate payment. Testimony stressed the importance in targeted funding for SCHIP enrollment outreach and the ability to coordinate enrollment information with other public programs. Given the overwhelming support, the Reference Committee recommends adoption.	
119	State Children's Health Insurance Program Reauthorization	<p>Resolution 119 asks that our AMA (1) strongly support the State Children's Health Insurance Program (SCHIP) reauthorization and lobby toward this end; (2) lobby Congress to provide \$60 billion in additional funding for SCHIP to ensure adequate funding of the SCHIP program and allow states to expand coverage to qualified children; and (3) lobby Congress to ensure predictable funding of SCHIP in the future.</p> <p>While the Reference Committee heard supportive testimony on Resolution 119, the diversity of state implementation and provision of services under SCHIP was revealed. Since some states are not taking full advantage of federal matching funds, and testimony highlighted the resulting discrepancy in services provided, the Reference Committee felt compelled to replace the word “allow” on line 36 to “incentivize.” In addition, as noted in the testimony provided on Council on Medical Service Report 1 and Resolution 129, general support of reauthorization rather than including a dollar amount is recommended. Given concern that payment to physicians is inadequate under SCHIP, the suggested amendment from the floor to include incentives for physicians to participate has been included. In addition, while testimony supported the request to lobby Congress to ensure predictable funding for SCHIP, the Reference Committees notes that this is consistent with existing policy (D-290.985).</p>	<p>RECOMMENDATION A: The Reference Committee recommends that the second resolve of Resolution 119 be <u>amended by insertion and deletion on lines 35 and 37</u> to read as follows:</p> <p>RESOLVED, That our AMA lobby Congress to provide \$60 billion in additional funding for SCHIP to ensure adequate funding of the SCHIP program, and allow <u>incentivize</u> states to expand coverage to qualified children, <u>and support incentives for physicians to participate</u> (Directive to Take Action); and be it further</p> <p>RECOMMENDATION B: The Reference Committee recommends that Resolution 119 be <u>adopted as amended</u>.</p> <p>HOD ACTION: Resolution 119 adopted as amended.</p>
120	Exclusion of Homeless Children from Deficit Reduction Act Documentation	Resolution 120 asks that our AMA advocate for exclusion of homeless infants, children, adolescents, and young adults from the requirements of the Deficit Reduction Act that they document their citizenship and identification under Section 6036 of the Deficit	HOD Action: That Resolution 120 be <u>adopted</u>.

	Requirements	<p>Reduction Act of 2005, “Improved Enforcement of Documentation Requirements.”</p> <p>The Reference Committee heard limited and supportive testimony on Resolution 120, and urges adoption.</p>	
129	Full Funding of the State Children's Health Insurance Program Reauthorization	<p>Council on Medical Service Report 1 recommends that the AMA: (1) continue to support health insurance coverage of children as a priority; (2) continue to support efforts to expand coverage to uninsured children who are eligible for the State Children’s Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms; and (3) continue to support the reauthorization of SCHIP in 2007.</p> <p>Resolution 129 asks that our AMA strongly support and advocate for full federal funding of the State Children’s Health Insurance Program (SCHIP) reauthorization at a level of at least \$60 billion. This amount will ensure that children currently enrolled in SCHIP do not lose coverage, and that children currently eligible but not yet enrolled can be covered as well, thus improving access to care for the children of every state.</p> <p>Testimony was heard on Council on Medical Services Report 1 commending the excellent synthesis of information and voicing strong support for SCHIP reauthorization. Suggested amendments to Recommendation 1 included adding “all” in front of children to be more inclusive and “strategic” in front of priority to demonstrate the importance of SCHIP in the AMA’s strategic priorities.</p> <p>There was disagreement whether to lobby for a dollar amount in the reauthorization process to ensure adequate future funding of the program as asked for in Resolution 129. The Reference Committee seriously considered the merits of including a specific dollar amount in response to disputed testimony on this point. The debate highlighted recent contradictory data on the specific dollar amount that is needed and convincing testimony cautioned against getting into the funding details. The Reference Committee agrees with maintaining broad support for reauthorization and not lobbying for a specific dollar amount so that the AMA is not limited in efforts to</p>	<p>RECOMMENDATION A: The Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 1 be <u>amended by insertion</u> to read as follows:</p> <p>That our American Medical Association continue to support health insurance coverage of <u>all</u> children as a <u>strategic</u> priority. (Directive to Take Action)</p> <p>RECOMMENDATION B: The Reference Committee recommends the recommendations contained in Council on Medical Service Report 1 be <u>adopted as amended in lieu of Resolution 129</u> and that the remainder of the report be <u>filed</u>.</p> <p>HOD ACTION: Council on Medical Service Report 1 <u>adopted as amended in lieu of Resolution 129</u> and remainder of the report <u>filed</u>.</p>

		support the reauthorization of this important program. Therefore, the Reference Committee recommends adoption of CMS Report 1 with suggested minor amendments to Recommendation 1 in lieu of Resolution 129.	
133	Universal Access to Health Insurance	<p>Resolution 133 asks that our AMA add publicly-funded universal access to health insurance to its list of options under discussion for increasing access to health coverage for all citizens of the United States.</p> <p>Testimony was largely opposed to Resolution 133. Opponents noted that AMA policy promotes a pluralistic range of public and private coverage options, but leaves no room for a single payer approach. The Reference Committee concurs with testimony against Resolution 133 and recommends that it not be adopted.</p>	HOD Action: That Resolution 133 <u>not be adopted.</u>
CMS 3	Financial Impact of Immigration on the American Health System (Resolution 235, A-06)	<p>Council on Medical Service Report 3 responds to the referral of Resolution 235 (A-06), which calls for the AMA to “ask the US Department of State to include on applications for visas to the US, a requirement mandating that visitors carry adequate health insurance valid during their stay in the US.” The report highlights concerns with Resolution 235 and recommends that the AMA support legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient.</p> <p>The sponsor of Resolution 235 (A-06) testified that the report failed to consider the requested action of mandating coverage for visitors to the US. The Council on Medical Service testified that it had considered the requested action, and enumerated the Council’s reasons for concluding that mandating coverage for US visitors potentially would be inappropriate and counterproductive. The Council testified that its recommendation addresses the essential issue of payment for physicians regardless of the immigration status of the patient.</p> <p>The Reference Committee concurs with the Council and supports adoption of the recommendation contained in this report.</p>	HOD ACTION: Council on Medical Service Report 3 <u>adopted</u> and remainder of the report <u>filed.</u>

208	Physical and Nutrition Education	<p>RESOLVED, That our American Medical Association support efforts to expand the federal No Child Left Behind legislation to include funding directed toward physical education and provision of nutrition education in schools (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA support state and federal legislation that would ensure that only healthy foods and beverages can be marketed to children (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA support state and federal legislation to require food nutrition information to appear in menus and on menu boards in chain restaurants. (Directive to Take Action)</p>	HOD Action: Placed on the reaffirmation calendar.
211	Ending Support for Pay-for-Performance and Public Reporting Programs	<p>Board of Trustees Report 18 recommends that (1) that our American Medical Association (AMA) reaffirm Policy H-450.947, which establishes the AMA’s Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles; and (2) that our AMA oppose the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. Resolution 202 asks (1) that our American Medical Association finds that pay-for-performance and public reporting programs may pose more risks to patients than benefits and calls for an immediate cessation of such programs by private and public third party payers; and (2) that our AMA Board of Trustees prepare a report on the risks and benefits of the pay-for-performance and public reporting programs and other elements of the US Department of Health and Human Services’ “Health Care Transparency Initiative” for presentation annually to the House of Delegates over the next three years. Resolution 203 asks (1) that our American Medical Association work with other medical and specialty associations to develop effective means of maintaining high quality of medical care which may include physician accountability to robust, effective, fair peer review programs, use of specialty-based clinical data registries, and participation in Patient Safety Organizations envisioned through the Patient Safety</p>	HOD ACTION: Board of Trustees Report 18 be adopted as amended in lieu of Resolutions 202, 203, 206, 210, 211, and 233 and the remainder of the report <u>filed</u>.

and Quality Improvement Act of 2005 and (2) that our AMA Board of Trustees report back on these activities to the House of Delegates at the next two AMA House of Delegate meetings. Resolution 206 asks (1) that our American Medical Association support the Physician Quality Reporting Initiative in its goals of: (a) Improving quality; (b) Using evidence-based guidelines that are transparent; (c) Working with physicians and physician organizations to ensure equity within the process; (d) Using accurate data and fair reporting; and (e) Providing fair and equitable program incentives; (2) that as a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on targeted populations and variable incentives in achieving quality, that CMS encourage and support pilot projects by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving cost-effectiveness, quality and appropriateness of care linked to clinical outcome measurements and patient safety; and (3) that our American Medical Association communicate this request to the Secretary of Health and Human Services and the Administrator of CMS. Resolution 210 – (1) that our American Medical Association hereby accept and affirm AMA President Plested’s pledge that in every one of our many endeavors, our positions will be driven by an unshakeable and uncompromising commitment to return the rightful prerogatives of the profession to the physicians of America; (2) that our AMA strongly oppose the use of any system by any public or private third party payer that purports to rank members of the profession, place physicians into tiers or institute payment mechanisms that are based on “performance measures” that are not clinically sound or are based on data that are incomplete or not statistically significant. and (3) that our AMA oppose any further federal “pay-for-performance” projects until the data obtained from the July through December 2007 federal experimental incentive has been thoroughly analyzed by our AMA. Resolution 211 asks (1) that our American Medical Association find that pay-for-performance and public reporting programs pose more risks to patients than benefits and calls for an immediate cessation of such programs by private and public third party payers; (2) that our AMA Chair and Board of Trustees advise the Secretary of Health and Human Services and the Ambulatory Care

Quality Alliance (AQA) that the AMA will no longer participate in the creation, development or implementation of the Secretary's "Transparency Initiative" or other pay-for-performance programs; and (3) that our AMA Board of Trustees: (a) mount a properly resourced public relations and media campaign by November 2007 to educate Americans on the risks and benefits of the pay-for-performance and public reporting programs and other elements of the Department of Health and Human Services' "Health Care Transparency Initiative" being promoted by Medicare and private insurance companies; and (b) present a progress report at the 2008 Annual Meeting. Resolution 233 asks (1) that our American Medical Association seek to assure that physicians be allowed to review their patient-specific data well in advance of any public release or payer tiering in order to correct information; and (2) that our AMA work with the health plans, and other appropriate entities to ensure an appeals process regarding inaccurate claims data.

The Reference Committee heard impassioned testimony on all aspects of public and private quality programs, such as pay-for-performance, pay-for-reporting, and physician economic profiling. The Reference Committee acknowledges the diversity of opinions concerning how to proceed with these critical issues, and concurs with all who testified that physicians' primary responsibility and intent in treating patients is to have the patients' best interest at heart and always to provide them with the highest quality of care. The Reference Committee has taken into account all views of those who testified and believes that a modified solution that encompasses Board Report 18, as well as many of the concepts proposed in Resolutions 202, 203, 206, 210, 211, and 233, is necessary to ultimately protect our patients. This modified solution is based on several tenets, as expressed by those who testified before the Reference Committee. Many fervently expressed that patients will only be protected by taking back our profession and simply saying "no" to pay-for-performance. Some expressed opposition to pay-for-performance on the basis of abuses imposed by private payer programs, including tiered networks that purport to maintain quality by arbitrarily penalizing physicians (and their patients) based on cost of care factors that are have no relationship to quality or specific patient need. This type of

		<p>program threatens quality of care.</p> <p>The Reference Committee also heard from others who just as fervently believe that it is imperative that physicians maintain a seat at the negotiating table. Otherwise, public and private payers will move forward with quality programs that may be seriously detrimental to patients and physicians. Others added that simply walking away from negotiations with the federal government on quality programs will also threaten our ability to negotiate with respect to other critical issues that impact patient access to and quality of care. Quality of care and other physician issues are not negotiated on a mutually exclusive basis, and care must be taken to evaluate our position against the backdrop of myriad issues in a very complex political environment. Based on the above considerations, the Reference Committee has crafted amendments to Board Report 18 to address the views of our House of Delegates, while maintaining the opportunity to continue to significantly and materially shape quality programs. This amended Board Report seeks to strengthen our hand in these negotiations and to ensure that physicians have the policy tools for effective advocacy. It encompasses many of the views presented in the Resolutions that were considered by the Reference Committee along with Board Report 18, including: (i) directing our support toward the development of quality programs that do not allow third parties to impose financial requirements that interfere with the patient-physician relationship; (ii) opposing the use of tiered and narrow physician networks that deny patient access to, and attempt to steer patients towards, certain physicians based on cost of care factors; (iii) physician development of programs, such as effective, peer review programs, and clinical data registries, for use in participating in quality initiatives; (iv) the development of and participation in pilot projects, such as Medicare's Physician Quality Reporting Initiative (PQRI), by state and medical specialty societies to demonstrate effective incentives for improving cost-effectiveness, quality and appropriateness of care; and (v) support for certain physician protections against programs that release patient-specific information or adverse payer actions to the public. The Reference Committee also recommends that our Board of Trustees prepare a report to determine the level of risk versus</p>	
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		<p>benefits to patients resulting from pay-for-performance and public reporting programs. The Reference Committee strongly urges that this report be conducted on a timely basis and that it discuss the distinctions between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives. Because of the rapidly evolving nature of pay-for-performance programs, annual reports for the next three years will be beneficial.</p> <p>The Reference Committee believes the foregoing recommendations will strengthen our position. It is critical to have the ability to navigate the pitfalls of an ever-changing and politically dynamic environment with respect to quality of care initiatives. Therefore, the Reference Committee recommends that Board Report 18 be adopted, as amended, in lieu of Resolutions 917 and 919 from I-06, as well as in lieu of Resolutions 202, 203, 206, 210, 211, and 233 from A-07.</p>	
221	Reauthorization of the Indian Health Care Improvement Act	<p>Resolution 221 asks (1) that our American Medical Association reaffirm Policies H-350.976, “Improving Health Care of American Indians,” H-350.981, “AMA Support of American Indian Health Career Opportunities,” H-295.897, “Enhancing the Cultural Competence of Physicians,” and D-350.992, “Medicaid Coverage for American Indian and Alaskan Native Children”; (2) that our AMA support reauthorization of the Indian Health Care Improvement Act; and (3) that our AMA report back on this issue at the 2008 Annual Meeting.</p> <p>The Reference Committee heard passionate and unanimous testimony in support of Resolution 221. The Reference Committee recognizes that the Indian Health Care Improvement Act is the cornerstone legal authority for provision of health care to American Indians and Alaska Natives. Due to the critical nature of this law and the testimony heard, the Reference Committee recommends adoption of Resolution 221.</p>	HOD ACTION: Resolution 221 adopted.
304	Medical School Language Electives in Medical School Curriculum	<p>Resolution 304, Medical School Language Electives in Medical School Curriculum, introduced by the Medical Student Section, asks our AMA to encourage medical schools to offer medical</p>	<p>RECOMMENDATION A: The Reference Committee recommends that the Resolved in Resolution 304 be <u>amended by deletion</u></p>

		<p>second languages, especially medical Spanish, to their students as electives.</p> <p>The Reference Committee heard testimony that it was important for medical students to have access to electives that would prepare them to communicate with populations for whom English is not the primary language. Depending on the location, other languages besides Spanish might be appropriate. It was generally agreed that the experiences should be elective.</p>	<p>on <u>line 19</u> to read as follows:</p> <p>RESOLVED, That our American Medical Association encourage all Liaison Committee on Medical Education- and American Osteopathic Association- accredited US medical schools to offer medical second languages, especially medical Spanish, to their students as electives. (Directive to Take Action)</p> <p>RECOMMENDATION B: The Reference Committee recommends that Resolution 304 be <u>adopted as amended</u>.</p> <p>HOD ACTION: Resolution 304 <u>adopted as amended</u>.</p>
308	Observerships for International Medical Graduates	<p>Resolution 308, Observerships for International Medical Graduates, introduced by the International Medical Graduates Section, asks our AMA, in cooperation with the IMG Section, to pursue the development of a model observership program and develop a campaign to educate physicians, residency program directors and hospital administrators about how to integrate and utilize the program within their systems.</p> <p>The Reference Committee heard some testimony about the utility of the concept of observerships. However, there are complexities to the issue that would benefit from study through referral. For example, there are legal issues in some states about observerships. Also, there were some concerns expressed about observerships creating stresses on patient and faculty resources. The study would assess the feasibility of developing standards for observership programs.</p>	<p>HOD ACTION: Resolution 308 <u>referred</u>.</p>
313	Evaluating the Effects of Physician Workforce Increases	<p>Resolution 313, Evaluating the Effects of Physician Workforce Increases, introduced by the American Academy of Pediatrics, asks our AMA to conduct an independent study of the potential effects of a 30% increase in U.S. medical school enrollment on the graduate medical education system, specialty selection, and</p>	<p>HOD ACTION: Resolution 313 <u>not adopted</u>.</p>

		<p>workforce planning.</p> <p>The Reference Committee heard testimony about the need for our AMA to independently study the effects of calls to increase the number of US medical school graduates. However, an independent study would be premature, impractical and expensive. There already are ongoing collaborations with the Association of American Medical Colleges (AAMC) as well as state and medical specialty societies. Our AMA will be able to do an independent assessment of the data collected by the AAMC. A report by the Council on Medical Education on workforce will be presented to the House of Delegates at the 2009 Annual Meeting. This report will address many of the topics covered by Resolution 313, though in only a preliminary form.</p>	
402	Promoting Prevention Strategies in Waiting Rooms	<p>Resolution 402 asks our AMA to encourage health care settings to place in their waiting rooms interactive media promoting preventive health measures empowering patients to become more proactive about their health.</p> <p>The Reference Committee heard limited but supportive testimony on this resolution. The language was amended to incorporate testimony that expressed the need to include alternative (i.e., low-tech) venues for providing information and education to patients in waiting rooms, in addition to interactive media.</p>	HOD ACTION: Resolution 402 <u>adopted as amended</u>.
405	Food Stamp Incentive Program	<p>Resolution 405 asks our AMA support legislation to provide a meaningful increase in the value of food stamps when used to purchase fruits and vegetables.</p> <p>Testimony heard by the Reference Committee was very supportive of Resolution 405. Additional testimony proposed an amendment to eliminate reimbursement for foods inconsistent with our AMA's principles of healthy choices. Other testimony suggested extending the proposed food stamp benefits to include whole grains. While the Reference Committee agrees with the spirit of the proposed amendments, a successful value-added food stamp program in California was limited to fruits and vegetables. In addition, the definition of whole grain products would need to be clarified. Likewise, current AMA policy does not specify a</p>	HOD ACTION: Resolution 405 <u>adopted</u>.

		consistent list of poor quality foods. Therefore, the Reference Committee recommends Resolution 405 be adopted without amendments.	
407	Health Impacts of High Fructose Syrup	<p>Resolution 407 asks our AMA to: (1) urge the US Food and Drug Administration (FDA) and the US Department of Agriculture (USDA) to require the food industry to use non-fructose sweeteners and limit the use of high fructose syrups in their products and (2) urge the FDA and the USDA to require the food industry to clearly label products containing high fructose syrups with an indication that "this product contains high fructose syrup; excessive intake of high fructose syrup may lead to obesity."</p> <p>The Reference Committee heard extensive testimony regarding Resolution 407. Testimony from a representative of the Corn Refiners Association indicated that: high fructose corn syrups have chemical compositions similar to sucrose, honey, and fruit juice concentrate; there is currently no evidence high fructose corn syrups affect obesigenic markers such as serum glucose and insulin, leptin, ghrelin, triglycerides, or appetite or satiety differently than sucrose; and high fructose corn syrups are generally recognized as safe by the Food and Drug Administration. Additional testimony opposed to Resolution 407 indicated that it was inappropriate to single out high fructose corn syrup but not other sugars or fats. Other testimony supported referral to compare the acceptability of various sugars. The Reference Committee is concerned that most of the data supporting the safety of high fructose corn syrup comes from industry and that few studies have specifically examined the health effects of high fructose corn syrup in comparison to other sugars. The Reference Committee therefore recommends Resolution 407 be referred.</p>	HOD ACTION: Resolution 407 <u>referred</u>.
413	Combating Obesity and Health Disparities	Resolution 413 asks our AMA support efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol.	HOD ACTION: Resolution 413 <u>adopted</u>.

		<p>The Reference Committee received testimony strongly supportive of Resolution 413. The Reference Committee agrees with testimony that educational efforts should be in alignment with federal food assistance programs. Based on the unanimity of the testimony, the Reference Committee recommends adoption of Resolution 413.</p>	
417	Establishment of a Federal Office of Men's Health	<p>Resolution 417 asks our AMA to encourage the establishment of an Office of Men’s Health at the US Department of Health and Human Services.</p> <p>Testimony was generally supportive of this resolution. It was recognized that men continue to have a shorter life expectancy than women, and may have specific health needs which this office could address. Several Offices of Women’s Health exist at the national level, and so the development of an Office of Men’s Health was thought to be fair and equitable. Some concern was expressed that the development of an Office of Men’s Health would minimize the need for continued efforts in women’s health, as some disparities in care still exist for women as well. However, based on the overall support for this resolution the Reference Committee recommends that Resolution 417 be adopted.</p>	<p>RECOMMENDATION A: The Reference Committee recommends that Resolution 417 be <u>amended on line 33</u> to read as follows:</p> <p>RESOLVED That our American Medical Association encourage the establishment of an Office of Men’s Health at the U.S. Department of Health and Human Services <u>to coordinate awareness, outreach, and outcomes on men’s health.</u></p> <p>RECOMMENDATION B: The Reference Committee recommends that Resolution 417 be <u>adopted as amended.</u></p> <p>HOD ACTION: Resolution 417 <u>adopted as amended.</u></p>
430	Reducing Trans Fats	<p>Resolution 430 asks our AMA to: (1) add language to its policies on nutrition to encourage and promote the reduction of trans fats in the American diet in order to maintain good health and lower the incidence of coronary artery disease and (2) issue a statement encouraging and promoting the reduction of trans fats in the American diet.</p> <p>Testimony heard by the Reference Committee was unanimously supportive of Resolution 430. The Reference Committee also heard testimony requesting this resolution specify that trans fats in foods be replaced with healthier fats or oils. Based on this request, the Reference Committee recommends that Resolution 430 be adopted as amended.</p>	<p>RECOMMENDATION A: The Reference Committee recommends that the first resolve of Resolution 430 be <u>amended by insertion and deletion on lines 27-29</u> to read as follows:</p> <p>That our American Medical Association add language to its policies on nutrition to encourage and promote the reduction of trans fats in the American diet in order to maintain good health and lower the incidence of coronary artery disease (Modify Current<u>New</u> HOD policy).</p> <p>RECOMMENDATION B:</p>

			<p>The Reference Committee recommends that the second resolve of Resolution 430 be <u>amended by insertion and deletion on lines 32-33</u> to read as follows:</p> <p>That our American Medical Association issue a statement encouraging and promoting the reduction of trans fats in the American diet, and that when trans fats are removed from foods, healthier fats or oils should be substituted.</p> <p>RECOMMENDATION C: The Reference Committee recommends that Resolution 430 be <u>adopted as amended.</u></p> <p><u>HOD ACTION: Resolution 430 adopted as amended.</u></p>
436	Gun Control	RESOLVED, That our American Medical Association reaffirm its policies against gun violence, as follows: Gun violence is a public health problem and AMA affirms the principle of banning the ownership, possession, purchase, sale, transport, or transfer of handguns, semi-automatic and automatic weapons and their ammunition, except for genuine sporting weapons, and for authorized law enforcement and security personnel. (Reaffirm HOD Policy)	HOD Action: Placed on the reaffirmation calendar.
BOT 9	Fighting the Obesity Epidemic	Resolution 409 (A-06), addressing issues related to fighting the obesity epidemic, was introduced by the Nebraska Delegation and referred to the Board of Trustees. The Board recommends that our AMA: (1) ask the Council on Science and Public Health (CSAPH) to critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting; (2) reaffirm Policy H-170.963; (3) consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles; and (4) ask the Council on Medical Service and the CSAPH collaborate to evaluate the	<u>HOD ACTION: Board of Trustees Report 9 adopted and remainder of the report be filed.</u>

		<p>relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35.</p> <p>Testimony received by the Reference Committee was strongly supportive of Board of Trustees Report 9. The Reference Committee commends our AMA Board of Trustees for writing an informative report on these important issues. Testimony supported the need for more research to assist physicians in diagnosing and treating obesity. Additional testimony was heard on the need to screen both waist circumference and body mass index in all patients, which will be addressed in the report to be developed by the Council on Science and Public Health as recommended. Given this testimony, the Reference Committee recommends adoption.</p>	
CSAPH 7	Hematopoietic Stem Cell Transplantation: Utilization of and Minority Representation on the National Bone Marrow Donor Registry	<p>Report 7 of the Council on Science and Public Health reviews the processes of bone marrow, PBSC, and UCB transplantation, and the efforts of the National Marrow Donor Program (NMDP) to recruit potential donors. It also addresses barriers to donation and strategies to increase the minority donor pool. The report recommends monitoring NMDP efforts to maintain a large and diverse Registry, encouraging the NMDP to expand its efforts to increase utilization of the Registry through projects aimed at increasing patient and physician awareness, and enhancing their efforts to increase the number of umbilical cord blood units donated to the Registry, particularly minorities. Physician organizations should work with the NMDP to develop information on umbilical cord blood donation to be disseminated in physicians' offices during prenatal visits. The report also recommends amending AMA Policy H-50.980—Increasing Bone Marrow Screening.</p> <p>The Reference Committee heard uniform testimony in support of this report. Several organizations commended the CSAPH on a well-written and informative report, and felt that the recommendations contained in the report appropriately addressed the issue of increasing representation on the National Marrow Donor Registry and donation of umbilical cord blood. Testimony suggested that information on umbilical cord blood donation be</p>	HOD ACTION: Council on Science and Public Health Report 7 <u>adopted as amended</u> and remainder of report <u>filed</u>.

		<p>supplied only in states in which public banks exist; however, CSAPH felt that this concern was adequately addressed in the body of the report. The Reference Committee therefore recommends that the recommendations of CSAPH Report 7 be adopted as written.</p>	
610	Renewed Focus on Domestic Violence	<p>Resolution 610 asks our AMA to renew its commitment to combat family and intimate partner violence by including violence prevention and education as part of the ongoing strategic planning process.</p> <p>The Reference Committee heard strong, compelling, and convincing testimony that our AMA should renew its commitment to combating family and intimate partner violence and recognize the importance of violence prevention and education by including the issue in its strategic planning process. While some testimony favored referral, the Reference Committee believes that the issue is critical for our patients, the public, and our profession and therefore recommends adoption.</p>	HOD ACTION: Resolution 610 <u>adopted</u>.
722	Inappropriate Use of Family Members for Interpreter Services	<p>Resolution 722 asks that our AMA amend Policy H-160.924 to add "treating physicians shall consider the use of ad hoc interpreters (family members or friends) to be a last resort for providing medical language assistance that is culturally sensitive and culturally competent." It also asks that our AMA work with other interested organizations to explore the development of a telephone-based or other form of interpreter service as an AMA member benefit, work with other interested organizations to develop payment mechanisms to support the availability of adequate interpreter services that both protect patient privacy and assure patient safety, and report back on this issue at the 2008 Annual Meeting.</p> <p>Testimony on this resolution was both mixed and extensive. Testimony in favor of the resolution stressed the drawbacks associated with using friends or family members as interpreters, especially with regard to the potential for jeopardizing patient confidentiality and patient care in cases where patients are reluctant to disclose personal information to family members.</p>	HOD ACTION: <u>Policies H-160.924, D-385.978 and H-385.928 reaffirmed in lieu of Resolution 722.</u>

		<p>While this may be true in some cases, the Reference Committee concurs with testimony indicating that often family members provide valuable information regarding medical history, and notes that this is the case with English-speaking patients as well as non-English speaking patients. Several speakers argued that using friends or family members as interpreters is often the only realistic and viable option for communicating with patients, and suggested that ad hoc interpreters be considered “an alternative” to professional interpreters, rather than “a last resort,” as called for in the resolution.</p> <p>Most speakers, including the resolution sponsors, were in agreement that requiring physicians to secure interpreter services is an “unfunded mandate,” with little progress being made on getting funding for these services. Some speakers suggested elimination of the Resolve in Resolution 722 asking our AMA to explore the development of an interpreter service as a member benefit, arguing instead that pressure should remain on the federal government to provide funding for these services.</p> <p>The Reference Committee recognizes that the issue of securing interpreter services is complex, and believes that existing Policy H-160.924 continues to offer the best expression of how language interpreters should be used in the context of the patient-physician relationship:</p> <p style="padding-left: 40px;">H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients’ choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools’</p>	
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limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03)

The Committee also notes that policies D-385.978 and H-385.928 address the need to ensure appropriate funding for interpreter services:

D-385.978 Language Interpreters

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. (Res. 907, I-03)

H-385.928 Patient Interpreters

Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government. (Res. 219, I-01; Reaffirmed: BOT Rep 8, I-02; Reaffirmation I-03)

Accordingly, the Committee believes that these policies should be

		reaffirmed in lieu of Resolution 722.	
CMS 8	Strategies to Address Rising Health Care Costs	<p>Council on Medical Service Report 8 recommends that our AMA:</p> <ol style="list-style-type: none"> 1. recognize that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; 2. support the following broad strategies for addressing rising health care costs: <ol style="list-style-type: none"> (a) Reduce the burden of preventable disease; (b) Make health care delivery more efficient; (c) Reduce non-clinical health system costs that do not contribute value to patient care; and (d) Promote “value-based decision-making” at all levels; 3. continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training; 4. continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers; 5. continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and 	HOD ACTION: Council on Medical Service Report 8 <u>adopted in lieu of Resolutions 701 and 719, and the remainder of the report filed.</u>

other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;

6. encourage the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
7. encourage third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. Consideration should be given to tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
8. support ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.

Resolution 701 asks that our AMA endorse appropriate cost effectiveness methodology in Medicare and health plan coverage policies.

Resolution 719 asks that, in the name of cost-effective, quality health care for all, our AMA include in its 2008 Agenda that the medical profession advocate for and become more vocal for appropriate, cost-effective, and reasonable care.

There was extensive testimony on these items. In discussing Council on Medical Service Report 8, several speakers commended the Council for the work it had done, but expressed concern about the many issues that had not been addressed in the report. Several members of the Council on Medical Service testified that defining and limiting the scope of Report 8 was one of the most challenging aspects of the report's development, and that the Council recognized that the recommendations in this report represent only a "first cut" at defining broad strategies for controlling costs. Members of the Council indicated the Council's

		<p>intent to address issues such as end of life care, pharmaceutical costs, defensive medicine, coordination of care, and the importance of the medical home in more detail in future reports, and also noted that the Council has incorporated a discussion of many of these issues in past reports. The Reference Committee concurs with testimony indicating that adoption of the Council's report as presented does not preclude future study of additional issues related to health care costs, and looks forward to the Council's continued study of these issues.</p> <p>The authors of Resolution 701 offered an amendment to the resolution asking that our AMA study cost-effectiveness methodologies of Medicare and other insurers. The Reference Committee notes that several recommendations in Council on Medical Service 8 address the need for improved cost-effectiveness studies. The authors of Resolution 719 spoke in support of adopting the recommendations in the Council report, and indicated that the intent of their resolution was addressed by the report. Accordingly, the Committee recommends adoption of the recommendations in Council on Medical Service Report 8 in lieu of Resolutions 701 and 719.</p>	
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