

APPENDIX

2012 ANNUAL MEETING OF THE HOUSE OF DELEGATES
REPORTS OF REFERENCE COMMITTEES

Reference Committee on Amendments to Constitution and Bylaws

- (1) BOARD OF TRUSTEES REPORT 4- NEW SPECIALTY
ORGANIZATION REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 4 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 4 adopted and the remainder of the report filed.

Board of Trustees Report 4 recommends that the Society of Cardiovascular Angiography and Interventions be granted representation in the American Medical Association House of Delegates.

There was no testimony for this item apart from an introduction by the Board of Trustees. The Society of Cardiovascular Angiography and Interventions has met the application criteria for national medical specialty organization representation in the American Medical Association House of Delegates. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 4 be adopted.

- (2) BOARD OF TRUSTEES REPORT 15- REMOVING FINANCIAL
BARRIERS TO LIVING ORGAN DONATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 15 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 15 adopted and the remainder of the report filed.

Board of Trustees Report 15 responds to Resolution 6-I-11 by the Resident and Fellow Section entitled "Removing Financial Barriers to Living Organ Donation." BOT Report 15 recommends adoption of new policy that supports federal and state laws that remove financial barriers to living organ donation.

Testimony unanimously supported this report for potentially increasing the pool of organ donors and protecting the interests of living organ donors. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 15 be adopted.

- (3) BOARD OF TRUSTEES REPORT 27- EQUAL ACCESS TO ORGAN
TRANSPLANTATION FOR MEDICAID BENEFICIARIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 27 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 27 referred.

Board of Trustees Report 27 responds to Resolution 1-I-11, "Equal Access to Organ Transplantation for Medicaid Beneficiaries". The resolution asked that our American Medical Association urge the Centers for Medicare and Medicaid Services to designate organ transplantation care and services covered by Medicare to be designated as mandatory benefits under Medicaid, and deemed lifesaving and essential, such that Medicaid coverage throughout the United States be uniform, predictable, and enabling regarding access to life-saving care. The Board of Trustees concluded that, on balance, policy and strategic considerations, including support of state flexibility and limiting benefit mandates, weigh against adoption of Resolution 1-I-11.

Testimony was very limited on this issue. Testimony against adoption of the recommendation in this report argued that neither health care nor science change at state borders. Your Reference Committee found these concerns appropriate, but acknowledges that the Board of Trustees carefully considered the conflicting goods at stake with this issue. Therefore, your Reference Committee recommends that the recommendation in Board of Trustees Report 27 be adopted.

**(4) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1- AMA
MINORITY AFFAIRS SECTION - ADDITIONAL BYLAWS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 1 be adopted and that the remainder of the report be filed.

**HOD ACTION: Council on Constitution and Bylaws Report 1 adopted and
the remainder of the report filed.**

Council on Constitution and Bylaws Report 1 introduces additional bylaws to the Minority Affairs Section Internal Operating Procedures. The report recommends that the Minority Affairs Section allow nonmember participation as provisional members for up to two years.

The majority of both live and virtual testimony was in favor of this report. While there was a minor concern regarding the rationale of having non-voting provisional members, it was pointed out several times that this practice is not only consistent with other sections, but has been shown to increase membership. Additionally, while alternative names were suggested to distinguish these provisional members from voting members, the term "provisional" is consistent with the bylaws and other sections with non-voting membership. Therefore, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 1 be adopted.

**(5) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 4-
ESTABLISHMENT OF AN AMA INTEGRATED PHYSICIAN PRACTICE
SECTION****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 4 be adopted and the remainder of the report be filed.

**HOD ACTION: Council on Constitution and Bylaws Report 4 adopted and
the remainder of the report filed.**

Council on Constitution and Bylaws Report 4 recommends bylaw changes to reflect the transition of Advisory Committee on Group Practice Physicians into the AMA Integrated Physician Practice Section, including membership and representation provisions.

Virtual testimony was minimal but favorable, applauding the Council on Long Range Planning and Development's criteria for establishing the new section. Therefore, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 4 be adopted.

(6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1-
PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 1 provides guidance to support physicians in making fair, prudent, cost-conscious decisions for care that meet the needs of individual patients and help to ensure availability of health care for others.

Most testimony before your Reference Committee favored the intent of the report. Some discussion addressed the concern that physicians would no longer be putting the interests of their individual patients first if they had to consider the costs of care and the impact on health care resources. However, your Reference Committee, agreeing with supporting testimony, believes that the report puts patients first and strikes an appropriate balance between considering patient interests and health care resources on a larger scale. The Council on Ethical and Judicial Affairs has given appropriate guidance in the context of limited resources, while leaving enough room for physicians to exercise their professional judgment when developing goals of care and treatment decisions with patients. Therefore, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted.

(7) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3- CEJA'S
SUNSET REVIEW OF 2002 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 3 recommends that the House of Delegates policies that are listed in the Appendix to Council on Ethical and Judicial Affairs Report 3 be acted upon in the manner indicated and the remainder of the report be filed.

No testimony was given regarding this report. Therefore, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted.

- (8) JOINT REPORT COUNCIL ON CONSTITUTION AND BYLAWS
/COUNCIL ON MEDICAL EDUCATION 1- SEPARATE ELECTION FOR
A PRIVATE PRACTITIONER WHO IS NOT A SALARIED FACULTY
MEMBER OF A MEDICAL SCHOOL TO THE COUNCIL ON MEDICAL
EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Joint Report Council on Constitution and Bylaws and Council on Medical Education 1 be adopted and that the remainder of the report be filed.

HOD ACTION: Joint Report Council on Constitution and Bylaws and Council on Medical Education 1 adopted and the remainder of the report filed.

This report, joint-authored by the Council on Constitution and Bylaws and the Council on Medical Education, proposes to remove a bylaw requirement that one member of the Council on Medical Education be a private practitioner who is not a salaried faculty member of a medical school.

In testimony, the Council on Medical Education explained that the current bylaw provision is unnecessary because the House of Delegates has always elected private practitioners to the Council. Opposing testimony stressed the importance of a diverse Council, recognizing the importance of representing practical medical experience. However, your Reference Committee believes that the practice of medicine is changing and the distinction between some academic and private practitioners is becoming blurred. Furthermore, it is becoming more difficult to categorize physicians as either purely academic or purely private practice. Your Reference Committee agreed with the authors' logic that the current bylaw is unnecessary. Therefore, your Reference Committee recommends that the recommendations in Joint Report Council on Constitution and Bylaws and Council on Medical Education 1 be adopted.

- (9) RESOLUTION 6- HPV VACCINE AND CERVICAL CANCER
PREVENTION WORLDWIDE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 6 be adopted.

HOD ACTION: Resolution 6 adopted.

Resolution 6 asks our AMA to amend existing policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" to recognize and adhere to the recommendations of the Federal Advisory Committee on Immunization Practices, which recommend vaccination of males.

Your Reference Committee heard overwhelming testimony in favor of adoption of this resolution. Comments were made that spending AMA resources on the study of this issue would be redundant and unnecessary. Therefore, your Reference Committee recommends that Resolution 6 be adopted.

- (10) BOARD OF TRUSTEES REPORT 26- SPECIALTY SOCIETY
REPRESENTATION IN THE HOUSE OF DELEGATES- FIVE-YEAR
REVIEW

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Board of Trustees Report 26 be amended by deletion and insertion on lines 43-45 to read as follows:

2. That the ~~American Medical Directors Association, American Pediatric Surgical Association, and American Society of Bariatric Physicians, Korean American Medical Association, and the Renal Physicians Association~~ representation in the House of Delegates be terminated at the conclusion of the 2012 Annual Meeting.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 26 be amended by insertion of a new third recommendation to read as follows:

3. That the American Medical Directors Association, American Society of Bariatric Physicians, and the Renal Physicians Association retain representation in the American Medical Association House of Delegates.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 26 be amended by insertion of a new fourth recommendation to read as follows:

4. That the Board of Trustees undertake a study of membership requirements with respect to the five-year review process given a declining membership in the organization.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 26 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 26 adopted as amended and the remainder of the report filed.

Board of Trustees Report 26 presents the review of the specialty organizations seated in the House of Delegates scheduled to submit information and materials for the 2012 American Medical Association Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020 and Bylaw 8.50. The report includes a recommendation that the American Medical Directors Association, American Pediatric Surgical Association, American Society of Bariatric Physicians, Korean American Medical Association and the Renal Physicians Association representation in the House of Delegates be terminated at the conclusion of the 2012 Annual Meeting.

Testimony overwhelmingly supported efforts to retain representation for the American Medical Directors Association, American Society of Bariatric Physicians, and the Renal Physicians Association. All three organizations testified and testimony focused on these organizations' contributions to our AMA, their long-standing membership and dedication to our AMA, and their efforts to increase AMA membership. The Korean American Medical Association and the American Pediatric Surgical Association did not submit any materials demonstrating their compliance with membership requirements and did not testify. The American Pediatric Surgical Association has indicated they will no longer be participating in our AMA. Much testimony focused, not just on the importance of retaining the American Medical Directors

Association, American Society of Bariatric Physicians, and the Renal Physicians Association because of their continued interest and commitment, but also on a need to examine the membership requirements. Particularly, it was believed to be inequitable for smaller societies to retain a percentage of membership equivalent to that of the larger special societies. One suggestion that your Reference Committee would like the Board of Trustees to consider is a formula that reflects the national percentage of physicians that belong to our AMA. One example would be the total number of AMA member physicians divided by the number of practicing physicians in the US. Such a formula would self-adjust as AMA membership increases or decreases over time. Your Reference Committee recommends review of this issue and therefore recommends adoption of Board of Trustees Report 26 as amended.

(11) RESOLUTION 9- FEMALE GENITAL MUTILATION - REDEFINING AMA POLICY H-525.980

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of the following Substitute Resolution 9:

Amend Policy H-525.980 to read:

The AMA (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) support legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; and (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; and (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, it's physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States. and (7) report any evidence of FGM noted during office visits or physical exams to child protective services and law enforcement as child abuse.

HOD ACTION: Substitute Resolution 9 adopted as amended.

Resolution 9 asks our AMA to amend current policy H-525.980 which opposes female genital mutilation with the following additional measures: to oppose the practice of female genital mutilation by physicians, to require reporting of female genital mutilation to law enforcement, and to widen awareness of the practice among physicians and trainees.

Testimony on this resolution was mixed. The resolution recognized the critical issue of FGM, the role of physicians in protecting patients from abuse, and the need to educate physicians about FGM. Issues of religious freedom were raised, but your Reference Committee recognizes that FGM is a cultural, not a religious, practice. With respect to the resolution's reporting requirement, testimony raised concerns about how to distinguish between abuse occurring within the US versus outside of the US, as well as when the abuse had occurred. Your Reference Committee felt that including a reporting requirement would create a redundancy with existing language in AMA policy. AMA policy already recognizes FGM as a form of child abuse. H-515.960, "Identifying and Reporting Suspected Child Abuse" also mandates that physicians report child abuse. Your Reference Committee believes the original language of AMA policy is stronger and broader when not narrowed to US physicians. Therefore, Your Reference Committee recommends adoption of Substitute Resolution 9 in lieu of original Resolution 9.

(12) RESOLUTION 7- SURROGATE CONSENT FOR LIVING ORGAN DONATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 7 be amended by deletion and insertion on lines 26-28 to read as follows:

~~RESOLVED, That the specific question of “non-vital” organ donation by surrogates acting on behalf of persons in persistent vegetative states be referred to the Council on Ethical and Judicial Affairs for review and guidance. That our AMA oppose the practice of surrogate consent for living organ donation from patients in a persistent vegetative state.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 7 be adopted as amended.

HOD ACTION: Resolution 7 adopted as amended.

Resolution 7 asks our AMA to direct the Council on Ethical and Judicial Affairs to study the practice of surrogate consent for living organ donation from patients in a persistent vegetative state.

Testimony widely condemned this practice. Current regulations, AMA policy, and the transplant community agree that living organ donors should consent to and understand the medical, surgical, and other circumstances which weigh on a decision to donate organs. Specifically, Opinion E-2.15, “Transplantation of Organs from Living Donors” states that “[t]he potential donor must have decision-making capacity.” Written and live testimony suggested that the practice of retrieving organs from PVS patients would be so abhorrent that CEJA study is not necessary and the practice should simply be opposed. Given this testimony and a desire to conserve AMA resources, your Reference Committee recommends adoption as amended.

(13) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2- AMA BYLAW 6.50 AND THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS' RESPONSIBILITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 2 be referred.

HOD ACTION: Council on Constitution and Bylaws Report 2 referred.

Council on Constitution and Bylaws Report 2 recommends amendments to the bylaws concerning the role of the Council on Ethical and Judicial Affairs. The recommendations of this report are limited to CEJA's role in investigating allegations of discrimination. The recommendations bring the national medical specialty societies, professional interest medical associations and the American Medical Association sections that participate in the House of Delegates into parity with CEJA's jurisdiction in investigating allegations of discrimination by constituent associations.

There was a significant concern raised in testimony about how this expansion of CEJA's role would work procedurally. Specialty societies accused of discrimination may not be willing to discuss facts in an AMA judicial hearing if a civil suit were ongoing, given that testimony provided to CEJA would not be privileged. Your Reference Committee discussed the implications of this report with in-house legal counsel and how

this particular provision of the bylaws would interrelate with ongoing civil litigation and related liability risks. Your Reference Committee believes this report needs further research and consideration. Therefore, your Reference Committee recommends that the recommendations of Council on Constitution and Bylaws Report 2 be referred.

(14) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 5-
PHYSICIAN RESPONSIBILITIES FOR SAFE PATIENT DISCHARGE
FROM HEALTH CARE FACILITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 5 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 5 adopted.

Council on Ethical and Judicial Affairs Report 5 provides guidance about physicians' role in collaborating with other health care professionals to develop discharge plans that are safe for individual patients.

Testimony on this issue was divided. There was significant testimony in favor of the report, recognizing the difficult but important role that physicians play in discharging patients from inpatient units and commending the Council on Ethical and Judicial affairs on addressing this issue. However, your Reference Committee also heard testimony regarding several concerns which warrant further review by the Council. Testimony was heard that questioned whether or not socioeconomic status was a clinically relevant or irrelevant consideration. Similarly, your Reference Committee believes that the preamble paragraph to the two recommendations in this report considered issues much broader than safe discharge itself, putting too great a burden on physicians. Your Reference Committee feels that the report would be more focused if the preamble were eliminated but the two recommendations were retained. Some testimony noted that the responsibility of physicians is medical, not social, agreeing that the report as written puts a heavy and unrealistic onus on physicians. Therefore, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 5 be referred.

(15) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 6 -
AMENDMENT TO E-9.011, "CONTINUING MEDICAL EDUCATION"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 6 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 6 referred.

Council on Ethical and Judicial Report 6 recommends amendments to E-9.011 "Continuing Medical Education" to reflect the evolution in standards of conduct of CME providers and the adoption of CEJA Report 1-A-11, "Financial Relationships with Industry in Continuing Medical Education".

Testimony universally supported referral of this report. Those who testified were concerned with item (d) in the recommendations, specifically the use of "commercial entity". Your Reference Committee agrees with the testimony heard, and suggests that the Council on Ethical and Judicial Affairs clarify this specific recommendation. Therefore, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 6 be referred.

(16) RESOLUTION 1- HPV VACCINATION FOR MINORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 1 be referred.

HOD ACTION: Resolution 1 referred.

Resolution 1 asks our AMA to develop and support model state legislation allowing unemancipated minors to consent to HPV vaccination without parental consent.

The testimony largely supported referral of this resolution, including the testimony from the authors of the resolution. Testimony noted that countries permitting minor consent for vaccination had a much larger vaccination rate than the US and applauded the attempt to reduce rates of HPV transmission and infection. Parents were recognized as a potential barrier to children receiving this important preventive measure. Overall, testimony reflected the many complex issues this resolution raises with respect to parental and pediatric decision-making, insurance coverage, and other special issues with respect to privacy and minor health, for which the Council on Ethical and Judicial Affairs could provide useful insight. Therefore, Your Reference Committee recommends that Resolution 1 be referred.

(17) RESOLUTION 2- USING TAX RETURNS TO IDENTIFY ORGAN DONATION STATUS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 2 not be adopted.

HOD ACTION: Resolution 2 not adopted.

Resolution 2 asks our AMA to study the implementation of a national database that would identify potential organ donors based on state and/or federal tax forms.

While testimony generally supported the aim of increasing the pool of eligible organ donors, testimony overwhelmingly rejected tax returns as an appropriate method for achieving this end. The legal access to private tax returns and the cost and feasibility of studying this idea were questioned, particularly in light of other existing and proven methods of increasing and identifying organ donors, such as state-wide registries. Therefore, your Reference Committee recommends that Resolution 2 not be adopted.

(18) RESOLUTION 3- SUPPORTING VOLUNTARY ORGAN DONATION FROM DEATH ROW PRISONERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 3 not be adopted.

HOD ACTION: Resolution 3 not adopted.

Resolution 3 asks that our AMA reexamine current Opinion E-2.06, "Capital Punishment" prohibiting physicians' participation in capital punishment related to organ retrieval from executed prisoners.

Testimony widely opposed the adoption of this resolution. The authors clarified that their resolution responds to several well-publicized cases where condemned prisoners were denied the opportunity to

donate organs. The Council on Ethical and Judicial Affairs reiterated Opinion E-2.06, "Capital Punishment," which forbids physicians consulting on modifying the method of execution to enable organ donation by the condemned. Transplant specialty groups and transplant physicians provided testimony that current transplant society policies prohibit this practice and that the technical and time-sensitive nature of organ recovery makes retrieval from condemned prisoners impractical. Moreover, testimony showed that prisoners cannot donate blood for a period post-incarceration because of infectious-disease concerns, which would apply to organs. Additionally, Your Reference Committee questions whether prisoners can exercise sufficient autonomy, free of coercion, to make a decision to donate. Therefore, your Reference Committee recommends that Resolution 3 not be adopted.

- (19) RESOLUTION 4- EDUCATING MEDICAL PROVIDERS AS FIRST-LINE RESPONDERS TO STOP HUMAN TRAFFICKING
RESOLUTION 8- THE RECOGNITION AND PROTECTION OF HUMAN TRAFFICKING VICTIMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 4 and Resolution 8 be referred.

HOD ACTION: Resolution 4 and Resolution 8 referred.

Resolution 4 and Resolution 8 both addressed physician response to patients who may be victims of human trafficking. Your Reference Committee felt that the resolutions were sufficiently similar to be considered together.

Resolution 4 asks our AMA to encourage physicians to act as first responders in addressing human trafficking, including the creation of a curriculum to screen for victims and the development of guidelines to educate health care professionals on how to intervene in human trafficking cases.

Resolution 8 asks our AMA to work with the Department of Health and Human Services to develop guidelines on identifying human trafficking victims and to encourage editors and publishers to include human trafficking screening information in medical training literature.

Testimony regarding these resolutions was varied but addressed similar issues. The importance of understanding and recognizing the signs of human trafficking was acknowledged, and there was much testimony heard in support of physician education on this issue. Testimony unanimously favored referral of these resolutions in order to study the best way for our American Medical Association to address this. Your Reference Committee believes there may be more appropriate ways for our AMA to impact this issue that do not add significant mandates or burdens on physician practices. Therefore, your Reference Committee recommends that Resolution 4 and Resolution 8 be referred.

- (20) RESOLUTION 5- SHARED STEWARDSHIP OF HEALTH CARE COSTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-450.938, H-373.997, and H-155.966 be reaffirmed in lieu of Resolution 5.

HOD ACTION: HOD Policies H-450.938, H-373.997, and H-155.966 reaffirmed in lieu of Resolution 5.

Resolution 5 asks that our AMA promote the concept of shared stewardship of health care costs through a number of mechanisms that support physicians' ability to be stewards in practice.

The resolution recognizes the role that physicians must play as stewards and suggests specific measures to enable physicians to do so. However, testimony criticized these measures for not putting patients first. Current Policies H-450.938 “Value-Based Decision-Making in the Health Care System,” H-373.997 “Shared Decision-Making,” and H-155.966 “Controlling Costs of Medical Care” successfully captures the intent of the resolution. While the author of the resolution testified on the importance of several issues, your Reference Committee feels these issues are amply addressed by Council on Ethical and Judicial Affairs Report 1, “Physician Stewardship of Health Care Resources” which your Reference Committee has recommended for adoption. Therefore your Reference Committee recommends reaffirmation of existing Policies H-450.938, H-373.997, and H-155.966.

H-450.938 Value-Based Decision-Making in the Health Care System

PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions. 2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality. 3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated. 4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients. 5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making. 6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08)

H-373.997 Shared Decision-Making

Our AMA: 1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice; 2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions; 3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation; 4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice; 5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and 6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area. (CMS Rep. 7, A-10)

H-155.966 Controlling Cost of Medical Care

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, house staff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general. (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08)

Reference Committee A (Medical Service)

(1) BOARD OF TRUSTEES REPORT 13 - NEED TO INCLUDE ASSESSMENT OF ECONOMIC IMPACT IN PRACTICE GUIDELINES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 13 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 13 adopted and the remainder of the report filed.

Board of Trustees Report 13 recommends that our AMA continue to monitor the methodological guidance, data collection, and data synthesis applied to evaluating the economic impact of implementing guidelines into clinical practice.

Your Reference Committee believes the report provides compelling information to support the recommendation that our AMA continue to monitor developments related to accurately and reliably evaluating the economic impact of practice guideline implementation. Accordingly, your Reference Committee recommends adoption of the recommendations in Board of Trustees Report 13.

Your Reference Committee also agrees with testimony emphasizing the overall importance of ensuring that professional judgment is not restricted by practice guidelines, and notes that several AMA policies (e.g., H-450.935, H-320.949 and H-460.909) clearly articulate our AMA's commitment to preserving the physician's right to exercise clinical judgment.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 - MEDICAID FINANCING REFORM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report filed.

HOD ACTION: Council on Medical Service Report 1 adopted as amended and the remainder of the report filed.

FIRST RECOMMENDATION IN ORIGINAL CMS REPORT 1

- (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or the medical care portion of the Medicaid program should be financed with federally issued premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow acute care patients and their families to purchase coverage individually and through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) for adults and modeled after the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for children with varying little minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnostic Diagnosis, and Treatment (EPSDT) program benefits and have no-cost sharing obligations. and eligibility under the current Medicaid program as described below:

~~(a) Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive tax credits that are large enough to enable them to purchase coverage with no cost-sharing obligations.~~

~~(b) Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive tax credits that are large enough to enable them to purchase coverage with limited cost-sharing.~~

~~(2) individuals who do not qualify for Medicaid, and have resources that are insufficient to purchase health insurance, should receive federally issued premium tax credits that are large enough to enable them to cover a substantial portion of coverage, with moderate cost-sharing.~~

~~(3) (2) in order to limit patient churn and assure continuity and coordination of care, there should be a seamless mechanism to quickly reassess the eligibility group and amount of tax credit with changes in income and family. adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.~~

(3) to support the development of a safety net mechanism, allow for presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.

(4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have auto enrolled should be permitted to change plans anytime within 90 days of their original enrollment.

~~(5) to support the development of a safety net mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.~~

(5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available as either a mandatory or optional services under Medicaid, but are not medical benefits per se.

(6) as individuals in the acute care the nonelderly and nondisabled populations transition into needing chronic care needs, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.

~~(8) (6) (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy)~~

(8) Our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.

Council on Medical Service Report 1 highlights the need for Medicaid financing reform, details the rationale for updating Policy H-165.855, outlines proposed alternatives to the FMAP formula, presents initiatives to address the dually eligible population, acknowledges the workforce shortage and includes Federation input.

Extensive, mixed testimony was heard on Council on Medical Service Report 1. One speaker questioned the use of the term "churn," however, your Reference Committee notes that it is a term used in health policy vernacular and therefore felt comfortable retaining it. Your Reference Committee was provided with amended language to consider, but felt the suggestions were adequately addressed in the report. For example, one suggestion requested that the language on presumptive assessment of eligibility and retroactive coverage in the stricken (5) be retained. Your Reference Committee highlights that the Council's rationale for striking this language is justified on page 11 of the report, which states that the 12-month continuous eligibility in (3) and auto-enrollment in (4) update and replace the need for the stricken language.

Providing quality medical care was of concern. In response, the Council on Medical Service testified that the report reaffirms Policy D-35.985, which advocates for physician-led, team-based care, including delivery models such as the patient-centered medical home. One speaker cautioned that there are more than 50 categories within the Medicaid program, which the speaker felt was not addressed in the report. Your Reference Committee notes that the modifications to Policy H-165.855 in the report were proposed in order to update the policy in the context of the Patient Protection and Affordable Care Act, which transitions Medicaid from a categorical program to one based on income. In addition, a speaker was concerned about those individuals who may fail to enroll in a plan. Your Reference Committee notes that (3) advocates for a mechanism to be developed to ensure that those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Finally, a question was raised about how quality plans would be ensured. Your Reference Committee was informed by the Council on Medical Service that the language stating that plans should be modeled after the Federal Employee Health Benefits Program for adults and modeled after the Early and Periodic Screening, Diagnosis, and Treatment program for children was included to ensure quality plans.

Even with all of the concerns raised in testimony, several speakers commended the Council on Medical Service for providing an excellent report that updates long-standing Medicaid policy on the provision of tax credits for this population, which is needed in the current fiscally constraining environment to provide choice in health insurance coverage as well as access to care. In addition, several speakers urged the House to consider that Medicaid beneficiaries do have the ability to select health insurance coverage just like the non-Medicaid population. Given the supportive testimony with the inquiries addressed, your Reference Committee recommends adoption of the recommendations in Council on Medical Service Report 1.

(3) COUNCIL ON MEDICAL SERVICE REPORT 5 - BASIC HEALTH PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 5 adopted and the remainder of the report filed.

Council on Medical Service Report 5 provides a summary of legislative and regulatory activity pertaining to the Basic Health Program (BHP), outlines relevant AMA Policy, highlights the potential impact of BHPs and discusses continuity of care and limiting patient churn.

The Council was commended on its efforts to quantify minimum requirements for basic health programs. Testimony raised a concern that the concept of using 12-month continuous eligibility as an alternative to a BHP and as a tool to reduce churn for Medicaid recipients, while appealing, seems to necessitate a thorough cost analysis to states. Testimony in response to this concern felt that the 12-month continuous eligibility criteria were a necessary component to ensure stability for the patient and to reduce the "hassle-factor" for the physician. As noted in testimony on Council on Medical Service Report 1, 12-month continuous eligibility is not a new concept. According to the Kaiser Commission on Medicaid and the Uninsured, as of January 2012, twenty-three (23) states currently provide 12-month continuous eligibility for children in Medicaid and 28 of the 39 states with separate CHIP programs do so. Kaiser concludes that providing a continuous year of coverage can also stretch administrative resources by reducing the number of children that "churn" on and off coverage and the workload associated with repeated enrollment and disenrollment. Testimony questioned the use of the term "churn," however, your Reference Committee notes that it is a term used in health policy vernacular and therefore felt comfortable retaining it.

Your Reference Committee believes that Council on Medical Service Report 5 provides much needed support for an alternative to the creation of BHPs in order to ensure coverage and choice. In addition, the report's principles for the establishment and operation of state BHPs will be valuable guidance for states that do choose to establish a BHP. As such, your Reference Committee recommends adoption of the recommendations in Council on Medical Service Report 5.

(4) RESOLUTION 110 - A NATIONAL TOOLBOX ON ACCESS TO AND DISTRIBUTION OF PHYSICIAN SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 110 be adopted.

HOD ACTION: Resolution 110 adopted.

Resolution 110 asks that our AMA advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients.

Supportive testimony was heard on Resolution 110, indicating that a national "Toolbox" on access to and distribution of physician services would serve as an excellent resource to share best practices. While support was voiced, concern was raised for the financial burden that the creation of a national "Toolbox" could have on the AMA. The author emphasized that the resolution is requesting that the AMA advocate for the creation of a Toolbox, not invest financial resources for creating one. In addition, it was highlighted that AMA Policies H-200.954 and H-205.992 are consistent with advocating for the development of such a Toolbox. Given supportive testimony, consistency with Policies H-200.954 and H-205.992, and clarification by the author, your Reference Committee recommends that Resolution 110 be adopted.

(5) RESOLUTION 116 - MAINTAINING MENTAL HEALTH SERVICES BY STATE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 116 be adopted.

HOD ACTION: Resolution 116 adopted.

Resolution 116 asks that our AMA support maintaining essential mental health services at the state level; state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment; increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness; and enforcement of the Mental Health Parity Act at the federal and state level. It also asks that the AMA consider mental health services when developing policy on essential benefits.

Supportive testimony on this resolution emphasized the need for the AMA to advocate for mental health services for a population that is often overlooked and unable to advocate for themselves. Your Reference Committee notes that the intent of Resolution 116 is consistent with Policies H-345.978 and H-345.976, which support access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders as well as encourage states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services. Regarding supporting mental health parity at the state level, our AMA has drafted model bills for states to use that address the availability of psychiatric benefits and payment discrimination for mental health disorders. One speaker noted that while the Mental Health Parity and Addiction Equity Act was signed into law in 2008, advocacy for health insurers to comply is still

necessary. Given supportive testimony and consistency with AMA policy and advocacy efforts, your Reference Committee recommends that Resolution 116 be adopted.

(6) RESOLUTION 121 - PATIENT ACCESS TO THERAPEUTICS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 121 be adopted.

HOD ACTION: Resolution 121 adopted.

Resolution 121 asks that our AMA work with other interested parties to ensure that payment for prescription medications and durable medical equipment is not denied because of an improperly suffixed institutional Drug Enforcement Agency (DEA) number or similar identifier.

Testimony was limited, yet supportive on Resolution 121. The sponsor explained that the rationale for bringing forth this resolution stems from health insurers not recognizing the Drug Enforcement Administration (DEA) or national physician identifier numbers when residents and fellows prescribe non-controlled medications and durable medical equipment. In these cases, the supervising faculty and facilities are participating providers, but a disconnect exists that requires patients to pay out of pocket or decline prescription medications that are included in their plan. Your Reference Committee concurs that this situation needs rectifying, and therefore recommends that Resolution 121 be adopted.

(7) RESOLUTION 123 - MEDICARE-MEDICAID DUAL ELIGIBLE
DEMONSTRATION PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 123 be adopted.

HOD ACTION: Resolution 123 adopted.

Resolution 123 asks that our AMA support efforts to better coordinate the care of dual eligibles; and to advocate that CMS delay implementation of the Medicare-Medicaid dual eligible demonstration program to allow beneficiaries and providers time to better understand the initiative. It also asks that the AMA work with CMS and the states to ensure that the demonstration does not disrupt established patient-provider relationships and current treatment plans; includes a rigorous evaluation; does not automatically enroll beneficiaries; and is designed to identify ways to better coordinate care for dual eligibles, rather than as a way to reduce provider payment rates.

Testimony was in unanimous support of Resolution 123. Several speakers stated concern that the Medicare-Medicaid dual eligible demonstrations would interfere with the patient-physician relationship if patients were automatically enrolled and had to change physicians. There was strong sentiment supporting patient choice of provider and the ability of patients to “opt-out” of demonstration programs. A state society voiced the opinion that the implementation of the program needed to slow down. One speaker requested that the AMA advocate the concerns outlined in Resolution 123 to the Centers for Medicare and Medicaid Services (CMS), since applications are still being accepted for this demonstration program. The Reference Committee was informed that the AMA is already in the process of drafting a letter to CMS outlining issues with the Medicare-Medicaid dual eligible demonstration program and that the issues outlined in Resolution 123, if adopted, could be included in this letter.

Your Reference Committee notes that the requests in Resolution 123 are consistent with Policies H-290.984 and H-415.988, which strongly oppose mandatory enrollment of Medicare and/or Medicaid patients in managed care plans and support choice of provider. Also consistent with the requests in

Resolution 123, Policy H-290.985 advocates phased implementation of Medicaid managed care programs to allow for a public comment period and to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers. The concerns raised in Resolution 123 about the dual eligible demonstration program are consistent with guiding principles contained in a newly developed AMA issue brief on the dual eligible demonstration program, which outlines principles based on existing policy with which these demonstrations can be reviewed. Given consistency with AMA policy and advocacy efforts, your Reference Committee recommends that Resolution 123 be adopted.

(8) BOARD OF TRUSTEES REPORT 12 - DISPENSING INAPPROPRIATE
QUANTITIES OF FORMULARY MEDICATIONS
RESOLUTION 113 – TESTING AND TREATMENT SUPPLIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 12 be amended by insertion and deletion on line 36 to read as follows:

1. That our American Medical Association support the protection of the patient-physician relationship from interference by payers via various utilization control mechanisms, ~~to include~~ including medication and testing and treatment supply quantity limits. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Board of Trustees Report 12 be amended by insertion and deletion on lines 38 – 42 to read as follows:

2. That our AMA work with ~~the health insurance industry and any other third party~~ payers to ensure that if they use quantity limits ~~in their prescription drug programs~~ for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies of a drug if medically necessary, and that any such process should place ~~the a~~ a minimum amount of burden upon patients, physicians and their staff. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Board of Trustees Report 12 be amended by insertion and deletion on page 4, lines 44 – 51, and page 5, lines 1 – 10 to read as follows:

3. That our AMA support interested state legislative efforts, federal action ~~legislative efforts and develop model state legislation~~ to ensure that ~~health insurers and other third party~~ payers that institute quantity limits ~~in their prescription plans for~~ prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies of a drug if medically necessary, including provisions such as the following:

- Physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
- physicians can appeal adverse determinations regarding quantity limitations;
- payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
- payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's ~~medication~~ quantity limitations;
- physicians with specialized qualifications may not be subject to ~~medication~~ quantity limits;
- payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
- payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in nonurgent situations and one working day in urgent cases; and,
- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision. (Directive to Take Action)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be adopted as amended in lieu of Resolution 113, and that the remainder of the report be filed.

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that the title of Board of Trustees Report 12 be changed to read as follows:

THIRD PARTY PAYER QUANTITY LIMITS

HOD ACTION: Board of Trustees Report 12 adopted as amended in lieu of Resolution 113, with a change in title, and the remainder of the report filed.

Board of Trustees Report 12 examines the issue of insurers and pharmacy benefit managers using quantity limits for medications, and recommends that the AMA work with payers to ensure that if they use quantity limits in their prescription drug programs, an exceptions process is in place which allows patients to access medications prescribed by their physicians, while also minimizing the administrative burden on physicians.

Resolution 113 asks that our AMA establish policy that a physician shall determine the frequency of testing or treatment that is necessary to manage a chronic disease, and the quantity of supplies needed for any time interval. It also asks that the AMA request that CMS modify existing restrictions on the number of supplies allowed per month by Medicare and allow physicians to determine appropriate testing or treatment intervals for optimum medical control, and that the AMA develop model state legislation to prevent third-party payers from imposing payment limits on medical supplies that override the physician's medical judgment in testing or treatment frequency.

Your Reference Committee concurs with testimony that Board of Trustees Report 12 provides strong direction for addressing issues associated with medication quantity limits imposed by insurance companies. A member of the Board of Trustees testified that the issues raised in Resolution 113 regarding limits on testing and treatment supplies are related to the medication quantity limits issues that are addressed in Board of Trustees Report 12. Although the focus of Board of Trustees 12 is quantity limits of prescribed medications, your Reference Committee believes that the recommendations in Board of Trustees Report 12 are equally relevant to insurers that impose quantity limits on testing and treatment supplies. Accordingly, your Reference Committee recommends amending the recommendations in and title of Board of Trustees Report 12 by broadening the language so that the new policy could encompass the specific issues addressed in Resolution 113.

In addition, your Reference Committee heard compelling testimony that patients can also be harmed by third-party payer policies that require patients to obtain minimum quantities of prescription drugs. The amended language clarifies that procedures should be in place to ensure that patients can access higher or lower quantities of medications, and that physicians can specify that patients receive limited quantities of certain drugs during initial trials of a medication, or when larger quantities could be problematic for at-risk patients.

(9) RESOLUTION 102 - IMPROVING MENTAL HEALTH SERVICES FOR PREGNANT AND POST-PARTUM MOTHERS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 102 be amended by the addition of a fourth resolve to read as follows:

RESOLVED, That our AMA continue to advocate for funding programs that address perinatal and postpartum depression through research, public awareness, and support programs (New HOD Policy).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 102 be adopted as amended.

HOD ACTION: Resolution 102 adopted as amended.

Resolution 102 asks that our AMA support improvements in mental health services for women during pregnancy and postpartum; support inclusive insurance coverage of mental health services during pregnancy through one-year postpartum; and support efforts to improve awareness and education about the risks of mental illness during pregnancy and postpartum.

Supportive testimony was heard on Resolution 102. Testimony acknowledged the need to advocate for insurance coverage of mental health services for pregnant and postpartum mothers in addition to increasing awareness of mental health issues during pregnancy, which together would help achieve the goal of improving mental health services for women during and after pregnancy. Additional testimony expressed support for extending mental health services for pregnant and postpartum mothers since Medicaid eligibility terminates by the end of the second month postpartum in some states. An amendment was offered requesting the AMA to advocate for funding programs that address perinatal depression, which your Reference Committee considered and concurs with in addition to adding some clarifying language to make it stronger.

Your Reference Committee notes that the intent of Resolution 102 is consistent with Policies D-420.996[2] and D-420.995, which state that the AMA will promulgate appropriate guidelines concerning the detection and treatment of depression during pregnancy, encourage further research into the treatment of depression during pregnancy, monitor the activities of relevant medical specialty societies on

this issue, including development of practice guidelines or policy statements, and assist as needed in educating the physician community. Given supportive testimony and consistency with policy, your Reference Committee recommends adopting Resolution 102 as amended.

(10) RESOLUTION 103 - ON-SITE EMPLOYER MEDICAL CLINICS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 103 be amended by insertion on lines 19 – 21 to read as follows:

RESOLVED, That our American Medical Association study the effect of on-site employer sponsored medical clinics on employee preventive health benefits and health access benefits (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 104 be amended by insertion on line 25 to read as follows:

RESOLVED, That our AMA develop guidelines for the operation of on-site employer-sponsored medical clinics, ensuring that employee privacy, safety, and access to preventive health are not compromised, and that such clinics are staffed by MD/DOs, or health care practitioners who have direct access to and supervision by MD/DOs, as consistent with state laws. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 103 be adopted as amended.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 103 be changed to read as follows:

ON-SITE EMPLOYER SPONSORED MEDICAL CLINICS

HOD ACTION: Resolution 103 adopted as amended, with a change in title.

Resolution 103 asks that our AMA study the effect of onsite employer medical clinics on employee preventive health benefits and health access benefits, and develop guidelines for the operation on onsite employer sponsored medical clinics.

There was supportive testimony on this resolution. Testimony suggested amending the first resolve and the title of the resolution to clarify that the clinics in question are sponsored by employers, as specified in the second resolve clause. Additional testimony suggested amended language that would specify that on-site employer sponsored medical clinics should not be staffed by non-physicians practicing independently of physician supervision. Your Reference Committee suggests amended language that is consistent with other AMA policies related to the role of non-physician practitioners. Your Reference Committee concurs that our AMA should take a close look at how employers are implementing on-site employer sponsored medical clinics, and recommends that Resolution 103 be adopted as amended.

(11) RESOLUTION 104 - VALUE-BASED INSURANCE DESIGN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 104 be amended by deletion on lines 16 - 18 to read as follows:

~~RESOLVED, That our American Medical Association conduct a study to evaluate the utility of value-based insurance design as a modality for enhancing patient care and reducing health care costs (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 104 be amended by deletion of the second resolve on lines 20 – 22 as follows:

~~RESOLVED, That our AMA Board of Trustees evaluate with the AMA Insurance Agency the feasibility of value-based insurance design for potential future inclusion in Agency health insurance products. (Directive to Take Action)~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 104 be adopted as amended.

HOD ACTION: Resolution 104 adopted as amended.

Resolution 104 asks that our AMA conduct a study to evaluate the utility of value-based insurance design as a modality for enhancing patient care and reducing health care costs, and that the AMA work with the AMA Insurance Agency (AMAIA) to evaluate the feasibility of including value-based insurance products in its offerings.

Testimony on this resolution cited studies and research that suggest that value-based insurance design has the potential to lower costs and improve patient outcomes if done correctly. Your Reference Committee agrees with testimony suggesting, in light of the large amount of data available on this topic, that the House could benefit from our AMA studying the work that has already been done on value-based insurance design, and synthesizing the information for the House. The proposed amendments to the first resolve clarify this intent. Your Reference Committee recommends deletion of the second resolve in light of testimony from the Council on Medical Service regarding the business operations of the AMAIA. The limited scope of the AMAIA's target market (i.e., small groups and individuals, which are associated with higher insurance risk), and the fact that the AMAIA does not custom-design insurance plans make it unlikely that the AMAIA could incorporate value-based insurance design products in its offerings.

(12) RESOLUTION 112 - HEALTH CARE SPENDING CONTROL AND AMBULATORY SURGICAL CENTERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 112 be adopted.

RESOLVED, That our American Medical Association seek legislation that requires third party payers to allow their plans' participating physicians to perform outpatient procedures at the appropriate site of service (hospital outpatient department, ~~accredited~~ ambulatory surgical center, ~~or accredited~~ office-based facility, or physician's office), chosen by the physician and the patient (Directive to Take Action); and be it further

RESOLVED, That our AMA seek legislation requiring third party payers to require equal facility copayments for alternative sites of service (hospital outpatient department, accredited ambulatory surgical center, or accredited office-based facility) for the delivery of outpatient procedures (Directive to Take Action); and be it further

RESOLVED, That our AMA draft model state legislation to require third party payers to permit physicians and patients to choose the appropriate site of service at which to perform outpatient procedures, and to require equal facility copayments for alternative sites of service (Directive to Take Action).

HOD ACTION: Resolution 112 -- 1st resolved referred for decision and Resolves 2 and 3 referred with report back .

Resolution 112 asks that our AMA seek legislation requiring insurers to allow physicians to use the certified ASC (either free-standing or hospital owned/based) in their community, and to have the same facility co-pay for both free-standing and hospital owned ASCs.

Testimony on this resolution indicated that private insurers often have different coverage policies associated with the use of ASCs, and some insurance companies will not contract with any free-standing ASCs in a particular area. Although our AMA has policy addressing site-of-service parity in physician payment rates (H-330.925), your Reference Committee is persuaded that additional policy could help highlight issues related to the effect of site-of-service policies on insurance benefits and coverage. The substitute language reflects testimony suggesting amendments to clarify the intent of the resolve clauses, and specifically call for our AMA to develop model state legislation addressing the issues raised in the resolution. Your Reference Committee recommends that Substitute Resolution 112 be adopted.

(13) RESOLUTION 114 - REIMBURSEMENT FOR COST OF SIGN LANGUAGE INTERPRETERS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 114 be amended by insertion on line 16 to read as follows:

RESOLVED, That our American Medical Association seek legislation and/or regulation to require health insurers to ~~adequately~~ fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 114 be adopted as amended.

HOD ACTION: Resolution 114 adopted as amended.

Resolution 114 asks that our AMA seek legislation and/or regulation to require health insurers to adequately reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

Testimony strongly supported the provision of and reimbursement for interpretive services for the hearing impaired. Relevant policies D-160.992 and H-285.985 were identified in testimony and one speaker suggested reaffirmation. Your Reference Committee is aware that our AMA has advocated on this issue in the past, but agrees with testimony that this is an unfunded mandate that continues to burden physician practices. An amendment was offered for the AMA to advocate that health insurers provide full payment for the cost of sign language interpreters. Support for this amendment was expressed by another speaker. Your Reference Committee agrees with the proposed amendment and therefore recommends that Resolution 114 be adopted as amended.

(14) RESOLUTION 117 - TRANSPARENCY OF PATIENT LIABILITY FOR
OUTPATIENT HOSPITAL AND OBSERVATION SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 117 be adopted.

RESOLVED, That our American Medical Association advocate that patients be subject to the same cost-sharing requirements whether they are admitted to a hospital as an inpatient, or for observation services (Directive to Take Action).

New Title: Patient Cost-Sharing Requirements for Hospital Inpatient and Observation Services

HOD ACTION: Substitute Resolution 117 adopted with a change in title.

Resolution 117 asks that our AMA advocate with CMS and commercial payers to require that providers who bill for outpatient hospital services inform patients of their out-of-pocket costs in advance of providing these services.

Testimony on this resolution emphasized the importance of ensuring price transparency so that patients are aware of their cost sharing obligations. Speakers expressed concern that the resolution as written would place an unreasonable burden on physicians by requiring that they provide cost-sharing information to patients. An important issue related to price transparency throughout the health care system is that physicians, as well as patients, are often unaware of third-party payment policies and cost sharing obligations. Policies D-155.994 and H-373.998 call for increased price transparency and better mechanisms to ensure that price information is available at the point of care. In addition, it was noted that, in some cases, discussing financial issues with hospital patients could be a violation of EMTALA rules. Your Reference Committee notes that Resolution 117 emphasizes the confusion associated with the "observation status" assigned to some Medicare beneficiaries receiving hospital services, and offers substitute language that would eliminate the discrepancy between the cost sharing for inpatient or observation services. Your Reference Committee believes that advocating that patients have a single copayment regardless of hospital admission status addresses the intent of Resolution 117 by eliminating confusion for patients and the burden to physicians, and recommends adoption of the substitute language.

(15) RESOLUTION 126 - TRANSITIONING MEDICARE TO A PREMIUM SUPPORT PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 126 be adopted.

RESOLVED, That our American Medical Association refine its policy regarding Medicare financing options, including a defined contribution program that would allow beneficiaries to purchase traditional Medicare or a private health insurance plan through a marketplace of competing health plans approved by the US Department of Health and Human Services or its designee. Our AMA should consider mechanisms to adjust contributions in order to ensure that health insurance coverage remains affordable for all beneficiaries (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2012 Interim Meeting (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 126 be changed to read as follows:

MEDICARE FINANCING OPTIONS

HOD ACTION: Substitute Resolution 126 adopted with change in title.

Resolution 126 asks that our AMA support transitioning Medicare to a premium support system, in which all beneficiaries will receive a set amount from the federal government amount to be used for the purchase of traditional Medicare or a private health insurance plan. Premium support amounts would vary based on income, health status, and local conditions. The resolution also asks that Policies H-330.869, H-385.961, D-390.986 and H-165.852 be reaffirmed, and that policies H-330.898 and D-330.917 be rescinded.

There was extensive, mixed testimony on this resolution. Resolution 126 was based on the recommendations in Council on Medical Service Report 2-A-12, which was withdrawn by the Council so that they could have the opportunity to do additional work before the issue was discussed by the House of Delegates. Testimony from the Council on Medical Service and others noted that Policy H-330.896 supports allowing Medicare beneficiaries to use a government contribution to purchase traditional Medicare coverage or private insurance coverage. The resolve clauses in Resolution 126 build on this policy, however, the Council and several other speakers in the Reference Committee strongly supported referring the matter to allow the Council more time to develop a thorough report that would address critical policy issues associated with introducing choice into the Medicare program. Particular concerns were raised about the need to give further consideration to ways to ensure that Medicare beneficiaries, especially those with low incomes and high medical costs, would be protected under a premium support program. The amended language acknowledges the ongoing work of the Council on Medical Service on this important issue, and specifically calls on our AMA to consider ways to implement a defined contribution program that will promote patient choice, ensure affordability for beneficiaries, and operate within a marketplace of competing health insurance plans. Finally, consistent with AMA policy (e.g., H-330.896 and D-330.937), your Reference Committee recommends using the term “defined contribution” rather than “premium support” to describe programs to facilitate Medicare patient choice. Your Reference Committee recommends that Resolution 126 be adopted as amended, with a change in title, which will

give the Council a foundation upon which to move forward with policy development necessary to ensure future Medicare viability.

(16) RESOLUTION 115 - OBESITY SHOULD BE CONSIDERED A CHRONIC DISEASE STATE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 115 be referred.

HOD ACTION: Resolution 115 referred.

Resolution 115 asks that our AMA recognize obesity and overweight as a chronic medical condition (de facto disease state) and urgent public health problem; recommend that providers receive appropriate payment from third-party payers for managing obesity; work with payers and governmental agencies to recognize obesity intervention as an essential medical service; and support the development of a comprehensive ICD code for medical services to manage and treat obese and overweight patients.

There was mixed testimony on this resolution. There was general consensus that obesity contributes to increased risk for a large number of chronic health conditions, and that physicians should be paid to help patients manage obesity. However, testimony was split regarding whether to classify obesity as a disease. Testimony in support of defining obesity as a disease highlighted evidence of metabolic abnormalities that persist following weight loss in formerly obese patients. Other speakers emphasized that it is important to recognize obesity is a risk factor for other diseases. Your Reference Committee notes that several AMA policies identify obesity as a major health problem, and call for better coding and payment mechanisms for the management and treatment of obesity, as called for in Resolution 115. However, based on testimony, your Reference Committee believes that Resolution 115 should be referred so that additional consideration can be given to the issue of whether to classify obesity as a disease.

(17) RESOLUTION 118 - PAYMENT RATE PARITY IN AMBULATORY CARE SETTINGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be referred.

HOD ACTION: Resolution 118 referred.

Resolution 118 asks that our AMA advocate with Medicare, and all payers, that they pay similar amounts for similar services across all ambulatory care settings.

Several speakers noted that the issues raised in Resolution 118 are complex, and there was strong support for referral. Speakers noted that the discrepancy in payment rates based on site of service creates incentives that could interfere with patients receiving treatment in the most appropriate setting. In addition, there was some concern that the resolution as written could result in lower rates for all services. Your Reference Committee concurs with testimony that this resolution should be referred so that the issues raised can be examined in more detail.

(18) RESOLUTION 101 - TRANSPORTATION AND ACCESSIBILITY TO
FREE MEDICAL CLINICS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-130.954 be reaffirmed in lieu of Resolution 101.

HOD ACTION: HOD Policy H-130.954 reaffirmed in lieu of Resolution 101.

Resolution 101 asks that our AMA encourage initiatives that address transportation as a barrier to care.

There was supportive testimony on this item, and comments emphasized the fact that lack of transportation can be a significant barrier to accessing necessary health care. Your Reference Committee concurs that this is an important issue, and agrees with testimony suggesting that Policy H-130.954, which encourages the development of non-emergency patient transportation systems, addresses the intent of Resolution 101.

H-130.954 Non-Emergency Patient Transportation Systems

The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. (Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03)

Additional testimony suggested that transportation issues could be minimized by exploring other methods of care delivery, such as telemedicine. However, your Reference Committee believes that the most effective way to address lack of transportation as a barrier of care is to promote the development of patient transportation options, as called for in Policy H-130.954. Accordingly, your Reference Committee recommends that Policy H-130.954 be reaffirmed in lieu of Resolution 101.

(19) RESOLUTION 105 - STUDIES TO IMPROVE CARE FOR UNINSURED
PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-165.957 and H-160.940 be reaffirmed in lieu of Resolution 105.

HOD ACTION: HOD Policies D-165.957 and H-160.940 reaffirmed in lieu of Resolution 105.

Resolution 105 asks that our AMA study successful strategies for improving patient access to quality and timely care and make recommendations for expanding these models nationally.

Testimony on Resolution 105 was mixed. One speaker noted that this topic has been studied often and proposed substitute language that the AMA collate all the state programs and evaluate them. Another speaker supported Resolution 105 as written. Additional testimony suggested reaffirming policy and encouraging continued efforts by the Council on Medical Service in studying this topic rather than begin a new study at this time. Your Reference Committee notes that the Council on Medical Service has issued CMS Report 1-A-12, also in Reference Committee A, and CMS Report 5-A-12, in Reference Committee G, both of which focus on strategies to improve care for underinsured patients. In addition, Policies D-165.957 and H-160.940 address the intent of Resolution 105, therefore, your Reference Committee recommends reaffirmation of these policies in lieu of Resolution 105.

D-165.957 State Options to Improve Coverage for the Poor

Our AMA (1) urges national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons; and (2) encourages state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage. (CMS Rep. 1, A-05)

H-160.940 Free Clinic Support

Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians. (Sub. Res. 113, I-96; Reaffirmed: BOT 17, A-04; CMS Rep. 1, A-09)
Resolution 106 - Studying Socioeconomic Status as a Determinant of Health

(20) RESOLUTION 106 - STUDYING SOCIOECONOMIC STATUS AS A DETERMINANT OF HEALTH**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policy H-350.974 be reaffirmed in lieu of Resolution 106.

HOD ACTION: HOD Policy H-350.974 reaffirmed in lieu of Resolution 106.

Resolution 106 asks that our AMA study mechanisms to monitor the impact of socioeconomic status (SES) on health-related risk factors, quality of care, and access to services.

Your Reference Committee commends the authors of Resolution 106 for highlighting the important issue of the relationship between SES and health. Testimony emphasized the fact that extensive research has demonstrated a relationship between socioeconomic factors and health status and outcomes. As noted by a member of the Council on Science and Public Health, the 2011 edition of the *Health* report, an annual snapshot of US health statistics produced by the Centers for Disease Control and Prevention, includes a special feature on SES and health. The sponsor of the resolution clarified that the intent of the resolution is for our AMA to develop measures by which SES can be attributed to health outcomes, with the goal of developing guidelines for how socioeconomic status should be addressed in a patient's care plan. The sponsors proposed amended language that would direct our AMA to ask appropriate organizations to collect data about mechanisms through which low SES leads to poor health outcomes, and a speaker noted that the World Health Organization is already engaged in this work, and publishes reports on the topic. Given that several other organizations are already gathering data that can help physicians address the connection between SES and health outcomes, your Reference Committee concurs with testimony that Policy H-350.974, which supports the development of performance measures that identify socioeconomic disparities in quality of care, expresses our AMA's commitment to this issue. Accordingly, your Reference Committee recommends that Policy H-350.974 (relevant section in **bold**) be reaffirmed in lieu of Resolution 106.

H-350.974 Racial and Ethnic Disparities in Health Care

Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association. The AMA emphasizes three

approaches that it believes should be given high priority: (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities **Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality.** Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. (CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03)

(21) RESOLUTION 107 - REDUCING BARRIERS TO PREVENTIVE HEALTH CARE AND COMPENSATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-425.987, H-185.954 and H-165.840 be reaffirmed in lieu of Resolution 107.

HOD ACTION: HOD Policies H-425.987, H-185.954 and H-165.840 reaffirmed in lieu of Resolution 107.

Resolution 107 asks that our AMA support the reduction of financial barriers to and the implementation of financial incentives for the delivery of cost effective preventive health care services, and that our AMA study the effects of improvements in financial incentives for the delivery of cost-effective preventive care.

Testimony on Resolution 107 was mixed. While general support was voiced, one speaker pointed out that existing policy captures the requests in this resolution and cautioned that the resolution's suggested study may not be the best use of AMA resources. Rather, it was suggested that our AMA monitor and report on the effects of improvements in financial incentives for the delivery of cost-effective preventive care so that best practices can be shared. The sponsor offered substitute language that was considered, however, your Reference Committee notes that Policies H-425.987, H-185.954 and H-165.840 address the requests in this resolution and the substitute language. As such, your Reference Committee recommends reaffirmation of these policies in lieu of Resolution 107.

H-425.987 Preventive Medicine Services

1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services. 2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review. (CMS Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmed and Appended: Res. 804, I-11)

H-185.954 Coverage for Certain Types of Well Care Examinations by Health Insurers

Our AMA: (1) will continue to facilitate the education of the American public and physicians as to the benefits of clinical preventive services, such as mammography screening and periodic physical examinations; (2) will continue to evaluate on a regular basis the benefits and cost-effectiveness of clinical preventive services guidelines; and (3) urges all health insurers to make available for purchase a wide variety of group and individual health insurance policies that provide coverage for a range of clinical preventive services. (Sub. Res. 108, A-97; Modified: CMS Rep. 7, A-00; Reaffirmed: CMS Rep. 3, A-02; Renumbered: CMS Rep. 7, I-05)

H-165.840 Preventive Medical Care Coverage for All

Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community. (Res. 827, I-08)

(22) RESOLUTION 108 - OUT-OF-NETWORK BENEFITS AND STANDARDIZATION OF PLAN TERMINOLOGY**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policies H-165.838, H-285.973 and H-320.968 be reaffirmed in lieu of Resolution 108.

HOD ACTION: HOD Policies H-165.838, H-285.973 and H-320.968 reaffirmed in lieu of Resolution 108.

Resolution 108 asks that our AMA advocate that every group health plan provide out-of-network coverage, and work with payers to develop standard terminology and definitions to help promote transparency.

There was limited, yet supportive testimony on Resolution 108. Your Reference Committee notes that Policies H-165.838 and H-285.973 support enrollees' access to out-of-network physicians and advocate that health plans not restrict appropriate referrals to medical and surgical subspecialists. As highlighted in testimony, the AMA "Truth in Out-of-Network Benefits" model bill includes standardized definitions for the terms necessary to clearly describe out-of-network benefits.

Policy H-320.968 supports the requirement of health plans to disclose in a clear and concise standard format to prospective enrollees information on coverage provisions, benefits, exclusions, review requirements, contractual provisions that would limit the services offered, referral restrictions and premium costs. The Patient Protection and Affordable Care Act legislated that every health insurer and group health plan must provide policy holders, applicants, and enrollees a summary of benefits and coverage using a uniform format developed by HHS that accurately describes the benefits and coverage under the plan.

Substitute language was offered requesting that the AMA encourage reporting by members when insurers fail to adhere to the identified policies and advocate for health insurer adherence to these AMA policies. Your Reference Committee notes that the AMA Private Sector Advocacy's online Health Plan Complaint Form located at https://amaassn.qualtrics.com/SE/?SID=SV_6JZxr2n1WWZHmle&SVID=Prod gives physicians and their staff an opportunity to report injustices by the insurance industry and request AMA assistance. Furthermore, to assist physicians with the process of filing a complaint with the AMA, a state medical association or state insurance regulatory agency, the AMA has compiled the complaint process procedures for every state. Information is available through an easy-to-use interactive map located at <http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/health-insurer-payer-relations/complaints-disputes/complaint-health-insurer-map.page>

Given that the requests in Resolution 108 are already being addressed by policy and advocacy efforts, your Reference Committee recommends that the following policies be reaffirmed in lieu of this resolution (relevant portions in **bold**):

H-165.838 Health System Reform Legislation

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps **c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials** d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care f. Implementation of medical liability reforms to reduce the cost of defensive medicine g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. **5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians...**

H-285.973 Access to Specialists and Subspecialists in Managed Care Plans

Our AMA: (1) advocates that all managed care plans be required to provide appropriate access, when geographically available, to representatives of all medical and surgical specialties and subspecialties; and (2) advocates that health plans not restrict appropriate referrals to medical and surgical subspecialists, including those specialties that are age group specific. (Sub. Resolution 707, I-94; Reaffirmed: CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 3, A-98; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, I-11)

H-320.968 Approaches to Increase Payer Accountability

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. **(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums.** (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97) (2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the

practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay. (3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11)

(23) RESOLUTION 109 - DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-90.995, H-165.846 and H-165.856 be reaffirmed in lieu of Resolution 109.

HOD ACTION: HOD Policies D-90.995, H-165.846 and H-165.856 reaffirmed in lieu of Resolution 109.

Resolution 109 asks that our AMA reaffirm Policy D-90.995; support adequate reimbursement by Medicaid and private insurers for testing to diagnose autism spectrum disorders; oppose the practice of excluding coverage for autism treatment services; and study programs for funding of autism treatment services.

Testimony supported the intent of Resolution 109 with caveats. One speaker proposed an amendment to the fourth resolved to strike the named organizations and replace them with "relevant medical organizations" since more entities than what is listed are interested in autism-spectrum disorders. In addition, a concern was raised that while autism is a significant problem and a challenge to many families and individuals, the appropriate treatment for ongoing care has not yet been agreed upon. This speaker suggested that closer examination of the evidence is needed before supporting the allocation of unlimited resources to uncertain outcomes and referred to a June 2011 report issued by the Oregon Health and Science University, entitled Applied Behavioral Analysis and Other Behavioral Therapies for the Treatment of Autism Spectrum Disorder. Your Reference Committee suggests accessing this report rather than supporting the requested study outlined in the fourth resolved.

Your Reference Committee notes that in addition to Policy D-90.995 highlighted by the author, Policy H-165.846 emphasizes AMA support for the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program to be used as the model for any essential health benefits package for children. In addition, Policy H-165.856 underscores the need to minimize benefit mandates to allow markets to determine benefit packages and permit a wide choice of coverage options. Given the concerns that were raised, and existing policy, your Reference Committee recommends that Policies D-90.995, H-165.846 and H-165.856 (relevant sections in **bold**) be reaffirmed in lieu of Resolution 109.

D-90.995 Early Intervention for Children with Developmental Delay

Our AMA will work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and urges physicians to assist parents in obtaining access to appropriate individualized early intervention services. (Res. 419, A-05; Reaffirmed in lieu of Res. 535, A-06)

H-165.846 Adequacy of Health Insurance Coverage Options

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. **2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.** (CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11)

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection; (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges; (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium; (5) Insured individuals should be protected by guaranteed renewability; (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices; (7) Guaranteed issue regulations should be rescinded; (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) **Benefit mandates should be minimized to allow markets to determine benefit packages**

and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11)

(24) RESOLUTION 111 - TRANSPARENCY IN HEALTH CARE COSTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-320.968, H-406.991 and H-330.896 be reaffirmed in lieu of Resolution 111.

HOD ACTION: Resolution 111 referred for decision.

Resolution 111 asks that our AMA support legislation, rules or regulations that will disclose physician fee schedules in contracts; make available the contracted discounts for medical providers; seek to assure that health plans be required to provide prospective enrollees with information regarding benefits, utilization review, financial arrangements, plan limitations, enrollee satisfaction statistics, and comparison of health plans; encourage CMS to assume a leadership role in providing cost and quality information available to patients and physicians; and seek assistance from CMS so that Medicare patients be provided incentives for economical choices in health care.

There was mixed testimony on Resolution 111, with various suggestions on how to address the requests in this resolution. One speaker voiced concern that the complexity of the issues would best be handled by a referral. Several speakers acknowledged existing policy, which simultaneously highlight that policy adequately addresses the key concepts in this resolution and supports continued action by the AMA on these issues.

The most relevant policies include Policy H-320.968, which supports the requirement of health plans to disclose in a clear and concise standard format to prospective enrollees information on coverage provisions, benefits, exclusions, prior authorization and review requirements, contractual provisions that would limit the services offered, referral restrictions and premium costs; Policy H-406.991 encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services; and Policy H-330.896 supports restructuring Medicare cost-sharing to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care.

As highlighted in testimony, the AMA has been active on the requests in this resolution through the AMA Advocacy Resource Center's drafting of various model bills, the AMA Private Sector Advocacy's development of the Health Insurer Code of Conduct Principles: Standards for Health Insurers' Administrative and Clinical Processes and the AMA Health Policy Group's series of publications entitled Getting the Most for our Health Care Dollars: Strategies to Address Rising Health Care Costs. In addition, your Reference Committee notes that the AMA has communicated on numerous occasions to CMS requesting the availability of claims data to patients and physicians, however, the AMA's position is that quality information should only be shared with patients and physicians if it is accurate and timely. This is consistent with testimony that voiced concern about revealing price information without also providing quality information.

Given the AMA's numerous activities on the requests in this resolution and concerns raised in testimony, your Reference Committee recommends that Policies H-320.968, H-406.991 and H-330.896 (relevant sections in **bold**) be reaffirmed in lieu of Resolution 111.

H-320.968 Approaches to Increase Payer Accountability

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. **(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums.** (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay. **(3) Accountability.** Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11)

H-406.991 Work of the Task Force on the Release of Physician Data

Principles for the Public Release and Accurate Use of Physician Data

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles: 1. Patient Privacy Safeguards - All

entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947). - Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983). 2. Data Accuracy and Security Safeguards - Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961). - Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961). - Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961). 3. Transparency Requirements - When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961). - The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947). - The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961). - Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931). 4. Review and Appeal Requirements - Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961). - When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947). 5. Physician Profiling Requirements - The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961). - Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (450.951). - When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used (no current policy exists). - Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services (no current policy exists). - Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes (no current policy exists). 6. Quality Measurement Requirements - The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947). - Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961). - These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data (no current policy exists). 7. Patient Satisfaction Measurement Requirements - Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs

particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982). - Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms (no current policy exists). - As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication (no current policy exists). (BOT Rep. 18, A-09; Reaffirmation A-10; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10; Reaffirmation A-11)

H-330.896 Strategies to Strengthen the Medicare Program

Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. **Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services such as those recommended by the US Preventive Health Task Force should also be encouraged.** Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits. (CMS Rep. 10, A-07)

(25) RESOLUTION 119 - VALUE-BASED PAYMENT MODIFIER

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-390.849, H-400.984, and D-400.985 be reaffirmed in lieu of Resolution 119.

HOD ACTION: HOD Policies H-390.849, H-400.984, and D-400.985 reaffirmed in lieu of Resolution 119.

Resolution 119 asks that our AMA support accurate quality and cost measurement in further development and improvement of the Value-Based Payment Modifier, and to determine an accurate methodology for price adjustment that would take into account the actual costs of physician practice.

Speakers emphasized the fact that the measures currently being used by the Centers for Medicare and Medicaid Services for the development of value-based payments are significantly flawed, and expressed concern that the value-based payment modifier program will be implemented based on inaccurate data that will harm physicians. The Chair of the Council on Medical Service testified that recent reports from the Council address the issues raised in this resolution. Council on Medical Service Report 4-A-11, "Pay for Value," provided background and recommendations related to value-based payment initiatives, and Council on Medical Service Report 1-I-11, "Practice Expense Data and the Medicare Economic Index (MEI)," provided background on the MEI and examined methodologies related to physician payment adjustments. Your Reference Committee believes that these reports did a thorough job of reviewing and analyzing the issues associated with payment modifiers, and notes that several AMA policies advocate

that physician payment adjustments should be based only on demonstrable differences in practice costs, using current, accurate, and reliable data. Your Reference Committee recommends reaffirmation of these policies in lieu of Resolution 119.

H-390.849 Medicare Physician Payment Reform

... 3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11)

H-400.984 Geographic Practice Costs

1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic payment areas for use in the new Medicare physician payment system. 2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices. (Sub. Res. 25, A-90; Modified: Sunset Report, I-00; Reaffirmation A-09; Modified: CMS Rep. 4, A-11; Reaffirmed and Appended: CMS Rep. 1, I-11)

D-400.985 Geographic Practice Cost Index

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues. (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11)

(26) RESOLUTION 120 - POLITICAL PROPOSALS FOR REDUCING COST OF HEALTH CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-165.888 be reaffirmed in lieu of Resolution 120.

HOD ACTION: HOD Policy H-165.888 reaffirmed in lieu of Resolution 120.

Resolution 120 asks that our AMA ask politicians who make proposals to reduce healthcare costs to answer more specific questions to detail the potential impact on all Americans.

Your Reference Committee appreciates the intent of this resolution, but is aware that the political process is complex, and that often high-level proposals are introduced as a way of stimulating conversation. Our AMA has numerous policies that guide AMA advocacy related to new policy proposals, including Policy H-165.888, which identifies elements that should be included or considered in health system reform proposals. Your Reference Committee concurs with testimony that supporting that this policy be reaffirmed in lieu of Resolution 120.

H-165.888 Evaluating Health System Reform Proposals

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: A. Physicians maintain primary ethical responsibility to advocate for their

patients' interests and needs. B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed. C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. H. True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

(27) RESOLUTION 122 - MEDICARE PRICE ADJUSTMENT
METHODOLOGY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-390.849, D-390.963, H-400.984, H-400.988 and D-400.985 be reaffirmed in lieu of Resolution 122.

HOD ACTION: HOD Policies H-390.849, D-390.963, H-400.984, H-400.988 and D-400.985 reaffirmed in lieu of Resolution 122.

Resolution 122 asks that our AMA review the Medicare Economic Index and analyze evidence to determine accurate weighting for the components of practice expenses; use actual physician practice survey data to recommend the most accurate methodology for the Practice Expense GPCI; determine the best method to measure the actual cost of physician labor for determination of the Work GPCI; and assess data needed to best represent organized medicine in payment and payment methodology proposals and recommend best methods for collecting such data. The resolution also asks our AMA to oppose any use of price adjustment methodology that involves GPICs; and support using the actual cost of physician labor for cost measurement in the Value-Based Payment Modifier Program and other Medicare payment programs.

Testimony on this item noted that the issues raised in this resolution have been debated many times in recent years, and that the House continually reaffirms policies that support using only current, accurate and reliable data to determine physician payment adjustments. The chair of the Council on Medical Service testified that the Council has developed two recent reports on the issues raised in this resolution, Council on Medical Service Report 1-I-11, "Practice Expense Data and the Medicare Economic Index (MEI)," which provided background on the MEI and examined methodologies related to physician payment adjustments, and Council on Medical Service Report 6-I-08, "Improving the Medicare Economic Index," which outlined opportunities for improvement of the composition of the MEI. The chair of the Council on Council on Medical Service also testified that our AMA is represented on the Medicare Economic Index Technical Advisory Panel, which was established by the Secretary of the Department of Health and Human Services conduct a technical review of the MEI. The review will include the inputs, input weights, price-measurement proxies, and productivity adjustment. As noted in the Reference Committee discussion on Resolution 119, several AMA policies advocate that physician payment adjustments should be based only on demonstrable differences in practice costs, using current, accurate, and reliable data. Accordingly, your Reference Committee concurs with testimony suggesting reaffirmation of the following policies in lieu of Resolution 122.

H-390.849 Medicare Physician Payment Reform

... 3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11)

D-390.963 Improving the Medicare Economic Index

Our AMA will urge the Centers for Medicare and Medicaid Services and the Medicare Payment Advisory Commission to review the Medicare Economic Index productivity offset and consider eliminating it or revising it so that it more accurately reflects the effects of productivity increase in medical practice. (CMS Rep. 6, I-08)

H-400.984 Geographic Practice Costs

1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic payment areas for use in the new Medicare physician payment system. 2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices. (Sub. Res. 25, A-90; Modified: Sunset Report, I-00; Reaffirmation A-09; Modified: CMS Rep. 4, A-11; Reaffirmed and Appended: CMS Rep. 1, I-11)

H-400.988 Medicare Reimbursement, Geographical Differences

The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas. (Sub. Res. 82, A-89; Reaffirmed: BOT Rep. DD, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Modified: CMS Rep. 4, A-11; Reaffirmed: CMS Rep. 1, I-11)

D-400.985 Geographic Practice Cost Index

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing

geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues. (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11)

(28) RESOLUTION 125 – ONCOFERTILITY AND FERTILITY PRESERVATION TREATMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-165.856 and D-330.918 be reaffirmed in lieu of Resolution 125.

HOD ACTION: HOD Policies H-165.856 and D-330.918 reaffirmed in lieu of Resolution 125.

Resolution 125 asks that our AMA support and lobby for legislation requiring coverage payment for standard fertility preservation therapy by all payers when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician.

Mixed testimony was heard on Resolution 125. The sponsor highlighted the challenges that many infertile individuals face since health insurance does not routinely cover payments for fertility preservation treatments, even in states with mandated infertility coverage. Testimony from the Council on Medical Service cautioned against supporting benefit mandates as it is inconsistent with AMA preference for allowing markets to determine benefit packages and permitting a wide choice of coverage options as outlined in Policy H-165.856. Your Reference Committee also notes that Policy D-330.918 supports clinically appropriate patient care and coverage determinations to reflect available scientific evidence. Additional testimony raised the concern that the second resolved is inconsistent with religious freedom. Your Reference Committee considered amended language provided by the author to better clarify the intent of the resolution. However, given the issues raised in testimony, and existing, relevant policy, your Reference Committee recommends that Policies H-165.856 and D-330.918 be reaffirmed in lieu of Resolution 125.

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection; (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges; (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium; (5) Insured individuals should be protected by guaranteed renewability; (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices; (7) Guaranteed issue regulations should be rescinded; (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to

the formation and operation of group purchasing alliances should, in general, be removed; **(b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options;** and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11)

D-330.918 Appropriateness of National Coverage Decisions

1. Our AMA will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care. 2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice. (Sub. Res. 120, A-11)

Reference Committee B (Legislation)

(1) BOARD OF TRUSTEES REPORT 18 - PHYSICIAN PROTECTION FROM RISK WITH ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 18 be adopted.

HOD ACTION: Board of Trustees Report 18 adopted.

The Board of Trustees recommends that, in lieu of Resolution 123-A-11, our AMA amend Policy D-385.963 by addition to read as follows, and that the remainder of the report be filed:

D-385.963 Health Care Reform Physician Payment Models

1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians; and (e) update the House of Delegates on these issues at the 2011 Annual Meeting. 2. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services. 3. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities. 4. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs. 5. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives. 6. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.

Your Reference Committee heard supportive testimony for Board of Trustees Report 18 and agrees that the report does an excellent job of detailing ongoing AMA efforts to assist physicians as they consider participation in ACOs. The report also provides background on AMA efforts to support comprehensive medical liability reform for physicians, irrespective of whether or not the physician participates in an ACO. In addition, your Reference Committee agrees with the recommendation that AMA policy be modified by including a provision calling on our AMA to provide model contract language that physicians can use in their negotiations with ACOs. Your Reference Committee also supports amending AMA policy to include an additional provision that calls on our AMA to work with states to ensure that current state liability reform laws protect physicians from claims or lawsuits that could arise from participation in a variety of health care payment and delivery reform models, including ACOs.

There was discussion in the Reference Committee hearing regarding a reference in current AMA policy to an update on ACO issues that was to be provided at A-11. This reference is included in current AMA policy because it was contained in a prior resolution, and the task has been completed. AMA staff will

provide the House of Delegates with status updates on the recommendations included in this report as part of the standard updates provided to the House of Delegates on actions taken to implement reports and resolutions at upcoming Interim and Annual meetings. Further, our AMA will continue to study and advocate on ACOs as part of our strategic focus to improve health care delivery and payment reform, and will provide extensive information to our members on an ongoing basis. Based on this, your Reference Committee does not feel that an additional annual report is necessary. Therefore, your Reference Committee recommends adoption of Board of Trustees Report 18.

(2) BOARD OF TRUSTEES REPORT 19 - COUNCIL ON LEGISLATION
SUNSET REVIEW OF 2002 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 19 be adopted.

HOD ACTION: Board of Trustees Report 19 adopted.

The Board of Trustees recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee considered Board of Trustees Report 19, and agrees with the recommendations for the policies in the Sunset Review. Your Reference Committee, therefore, recommends adoption of Board of Trustees Report 19.

(3) RESOLUTION 203 - PPACA EDUCATION DIRECTIVE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 203 be adopted.

HOD ACTION: Resolution 203 adopted.

Resolution 203 asks that our American Medical Association educate the physicians of these United States in the details and implementation of the PPACA legislation. (Directive to Take Action)

Your Reference Committee heard testimony in strong agreement with this resolution. Your Reference Committee agrees that the *Patient Protection and Affordable Care Act* (PPACA) involves numerous comprehensive initiatives that impact physicians. We recognize our AMA's extensive and ongoing efforts to educate the physician community concerning these initiatives, including education about our AMA's efforts to revise provisions in PPACA that are inconsistent with AMA policy, through our AMA web site and other forums, such as our AMA Advocacy Update and Insights. Your Reference Committee believes it is important for our AMA to continue to educate physicians about PPACA implementation, and therefore recommends adoption of Resolution 203.

(4) RESOLUTION 212 - MEDICARE RECORDS RETENTION AND
OVERPAYMENT RECOUPMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 212 be adopted.

HOD ACTION: Resolution 212 adopted.

Resolution 212 asks (1) that our American Medical Association communicate to the US Department of Health and Human Services its strong objection to the proposed plan to collect overpayment of Medicare services within 60 days of discovery, regardless of how this might affect the cash flow and the solvency of a medical practice (Directive to Take Action); and (2) that our AMA express to the US Department of Health and Human Services its strong objection to the proposed rule which would require practices or auditors to report any overpayments that were discovered within ten years of the date the funds were received instead of the current six-year requirement, due to the burden this would place on physicians' practices, which in essence is another unfunded mandate. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 212, and notes that on April 16, 2012, our AMA expressed to the U.S. Department of Health and Human Services our strong objection to its proposed rule that would require practices or auditors to report any overpayments that were discovered within ten years of the date the funds were received instead of the current six year requirement, due to the burden this would place on physician practices. Your Reference Committee, therefore, recommends adoption of Resolution 212.

(5) RESOLUTION 214 - REPEAL OF CMS' 2012 MPPR RULE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 214 be adopted.

HOD ACTION: Resolution 214 adopted.

Resolution 214 asks (1) that our American Medical Association actively support legislation to repeal the 25% MPPR recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule (Directive to Take Action); and (2) that our AMA work to prevent further broadening of CMS multiple procedure payment reduction proposals until thoroughly studied by CMS. (Directive to Take Action)

Your Reference Committee heard Resolution 214, and recognizes that our AMA has already strongly advocated against CMS' implementation of the multiple procedure payment reduction policy for professional services. Your Reference Committee, therefore, recommends adoption of Resolution 214.

(6) RESOLUTION 215 - PROTECTING PHYSICIANS WITH MULTIPLE TAX ID NUMBERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 215 be adopted.

HOD ACTION: Resolution 215 adopted.

Resolution 215 asks that our American Medical Association support legislation and/or regulation to prevent managed care organizations from requiring physicians to participate under all of their Tax ID Numbers if they participate under one Tax ID Number. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 215. Those who testified indicated the need for physicians to have the ability to negotiate separate contracts for services they provide in multiple, varying locations. Your Reference Committee agrees, and recommends that Resolution 215 be adopted.

(7) RESOLUTION 216 - TIME LIMITS FOR RECOVERY AUDITS
CONTRACTOR REVIEWS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 216 be adopted.

HOD ACTION: Resolution 216 adopted.

Resolution 216 asks that our American Medical Association petition the Centers for Medicare & Medicaid Services to limit Recovery Audit Contractor reviews to less than one year from payment of claims. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 216, and agrees that audits imposed by Recovery Audit Contractors (RACs) are often highly disruptive and very expensive for physician practices. Your Reference Committee believes that RACs should work constructively to identify true improprieties and recover overpayments, and that there should be reasonable time limits imposed for such reviews. Your Reference Committee, therefore, recommends adoption of Resolution 216.

(8) RESOLUTION 220 - EXTENSION OF STARK LAW EXCEPTION AND
ANTI-KICKBACK STATUTE SAFE HARBOR FOR DONATION OF EHR
PRODUCTS AND SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 220 be adopted.

HOD ACTION: Resolution 220 adopted.

Resolution 220 asks (1) that our American Medical Association adopt policy supporting the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (HER) products and services (New HOD Policy); and (2) that our AMA advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of Resolution 220. Your Reference Committee agrees with those who testified that the donation of electronic health record (EHR) products and services provides physicians with much-needed assistance in purchasing, implementing, adopting, and maintaining EHRs. Your Reference Committee, therefore, recommends that Resolution 220 be adopted.

(9) RESOLUTION 229 - PHYSICIAN'S ABILITY TO NEGOTIATE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 229 be adopted.

HOD ACTION: Resolution 229 adopted.

Resolution 229 asks (1) that our American Medical Association pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment (Directive to Take Action); and (2) that our AMA find and improve business models for physicians to

improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. (Directive to Take Action)

Your Reference Committee heard testimony strongly in support of Resolution 229. Your Reference Committee agrees that antitrust relief is necessary for physicians to effectively negotiate with health insurance companies on behalf of themselves and their patients. Your Reference Committee also recognizes that our AMA has been actively working to promote business models that help physicians to improve their ability to maintain a viable economic environment. Your Reference Committee therefore recommends adoption of Resolution 229.

(10) RESOLUTION 235 - OPPOSITION TO FDA'S RX TO OTC PARADIGM SHIFT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 adopted.

Resolution 235 asks that our American Medical Association: (1) submit comments during the public comment period expressing our concerns with the Food and Drug Administration's (FDA's) proposed paradigm shift; (2) continue to monitor FDA's action on this issue; (3) encourage the FDA to study the cost implications switching prescription drugs to over-the-counter status will have on patient out of pocket costs; and (4) strongly encourage the FDA to initiate a formal public comment process before reclassifying any prescription drug to over-the-counter status. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 235. Many expressed concern about an FDA concept involving the use of technology and other restrictions to reclassify drugs that are currently prescription to non-prescription. Your Reference Committee acknowledges that Resolution 235 is consistent with AMA advocacy activities, and recognizes that this resolution accurately describes the issue of moving drugs that are currently prescription-only to over-the-counter status. Therefore, your Reference Committee recommends adoption of Resolution 235.

(11) RESOLUTION 244 - ELECTRONIC PRESCRIPTIONS FOR CONTROLLED SUBSTANCES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 244 be adopted.

HOD ACTION: Resolution 244 adopted.

Resolution 244 asks (1) that our American Medical Association investigate regulatory barrier to electronic prescription of controlled substances so that physicians may successfully submit electronic prescriptions for controlled substances (Directive to Take Action); and (2) that our AMA work with the Centers for Medicare and Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-Prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 244, and agrees that it is critical for our AMA to advocate for removal of legal barriers to electronic prescription of controlled substances and that the requirement to electronically prescribe controlled substances should be eliminated until such time as the necessary protocols are in place for electronic prescribing software vendors and pharmacy

systems to easily receive these electronic prescriptions. Your Reference Committee acknowledges that our AMA is currently advocating for these goals, and therefore we recommend adoption of Resolution 244.

(12) RESOLUTION 201 - SUPPORT FOR DRUG COURTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 201 be amended by insertion and deletion on lines 21-23 to read as follows:

RESOLVED, That our American Medical Association support the establishment of drug courts ~~as an alternative to incarceration and as an a more effective method of intervention for individuals with addictive disease who are means of overcoming drug addiction for drug-abusing individuals~~ convicted of nonviolent crimes.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 201 be adopted as amended.

HOD ACTION: Resolution 201 adopted as amended.

Resolution 201 asks (1) that our American Medical Association support the establishment of drug courts as an alternative to incarceration and as a more effective means of overcoming drug addiction for drug-abusing individuals convicted of nonviolent crimes (New HOD Policy); and (2) that our AMA encourage legislators to establish drug courts at the state and local level in the United States. (New HOD Policy)

Your Reference Committee heard testimony on Resolution 201 regarding whether the establishment of a separate court system to handle drug addiction cases would be more effective in aiding and treating drug-abusing individuals than the current court system. Your Reference Committee agrees that pursuing solely punitive penal action in drug addiction cases is not the solution. Your Reference Committee notes that there are drug courts located throughout the country, and current AMA policy supports working with state and local health departments to develop plans with the court systems and the medical and public health communities to prevent and control drug addiction. Your Reference Committee received testimony asking for clarification of certain addiction medicine terminology and further clarifying language on the purpose of drug courts and agrees that the suggested language improves the resolution. Therefore, your Reference Committee recommends that Resolution 201 be adopted as amended.

(13) RESOLUTION 202 - SUPPORT FOR MEDICAL AMNESTY POLICIES FOR UNDERAGE ALCOHOL INTOXICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 202 be amended by insertion on line 22 to read as follows:

RESOLVED, That our American Medical Association support efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment for underage drinking when seeking emergency medical attention for themselves or others. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 202 be adopted as amended.

HOD ACTION: Resolution 202 adopted as amended.

Resolution 202 asks that our American Medical Association support efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment when seeking emergency medical attention for themselves or others. (New HOD Policy)

Your Reference Committee heard supportive testimony of Resolution 202. Testimony presented stated that medical amnesty policies, that protect underage drinkers from legal consequences when seeking emergency medical attention for themselves or another, lead to better results. For example, there is an increase in students calling for help to assist a friend as well as an increase in students receiving follow-up education and assessment. Testimony also supported the amendment recommended by your Reference Committee in our preliminary Virtual Reference Committee report. This amendment was due to concerns that the resolution is worded too broadly and could protect underage drinkers from criminal activity. Other testimony addressed that the medical amnesty protection afforded to underage drinkers should also be extended to situations involving illegal drug use. Your Reference Committee recognizes that such protection could incentivize individuals in these situations to seek emergency medical attention, but believes that protection for illegal drug use has greater complications that must be fully discussed as a separate issue. Your Reference Committee encourages those who testified in this regard to bring forth a separate resolution at a future meeting so these issues can be fully aired and discussed. Your Reference Committee therefore recommends adoption of Resolution 202, as amended.

(14) RESOLUTION 210 - STIMULATE ANTIBIOTIC RESEARCH AND DEVELOPMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 210 be amended by insertion and deletion on line 27 to read as follows:

RESOLVED, That our American Medical Association support legislation requiring the re-evaluation of FDA guidelines for clinical trials of antibiotics, including an increase in the period of ~~patent protection~~ market exclusivity, ~~and giving antibiotics priority review.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 210 be adopted as amended.

HOD ACTION: Resolution 210 adopted as amended.

Resolution 210 asks that our American Medical Association support legislation requiring the reevaluation of FDA guidelines for clinical trials of antibiotics, including an increase in the period of patent protection, and giving antibiotics priority review. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 210. Your Reference Committee believes manufacturers need regulatory incentives to promote the next generation of antibiotics. We also acknowledge that the U.S. House and Senate each passed their respective versions of PDUFA (the FDA Reform Act of 2012), and are currently working to reconcile their respective versions of the bill. This legislation would provide priority and expedited approval for next generation antibiotics, direct the GAO to evaluate whether the FDA should have new authorities to implement a significantly modified approval

process, e.g., clinical trials for limited target populations, and provide for extension of market exclusivity. And one clarifying note, the AMA-supported "Generating Antibiotic Incentives Now Act" (GAIN) was sponsored by Representatives Phil Gingrey, MD (R-GA) and Gene Green (D-TX) and Senators Richard Blumenthal (D-CT) and Bob Corker (R-TN).

Your Reference Committee recommends two changes to Resolution 210. The first change reflects that the Food and Drug Administration (FDA) confers extensions on market exclusivity, not extensions on patent life, so your Reference Committee recommends changing the resolution to reflect this. Second, your Reference Committee agrees with the FDA that not all antibiotics need priority review and that Resolution 231 establishes a good process for expedited review for drugs with a critical need. With this in mind, your Reference Committee recommends deleting the last clause from Resolution 210. Therefore, your Reference Committee recommends that Resolution 210 be adopted as amended.

- (15) RESOLUTION 213 – REVISE THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
RESOLUTION 239 – CONTINGENCY TO ADVOCATE FOR MEDICAL CARE OF THE AMERICAN PEOPLE
RESOLUTION 243 – REPEAL PUBLIC LAW 111-148, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 239 be amended by deletion on line 25 to read as follows:

RESOLVED, That our American Medical Association reaffirm the following House of Delegates Policies:

H-165.833 Amend the Patient Protection and Affordable Care Act (PPACA);
H-165.865 Principles for Structuring a Health Insurance Tax Credit;
H-165.985 Opposition to Nationalized Health Care;
H-165.920 Individual Health Insurance;
H-165.882 Improving Access for the Uninsured and Underinsured;
H-140.984 Physicians' Involvement in Commercial Ventures;
H-165.845 State Efforts to Expand Coverage to the Uninsured;
~~H-165.855 Medical Care for Patients with Low Incomes;~~
H-165.856 Health Insurance Market Regulation;
H-165.904 Universal Health Coverage;
H-165.852 Health Savings Accounts;
H-165.838 Health System Reform Legislation;
H-180.978 Access to Affordable Health Care Insurance through Deregulation of State Mandated Benefits; and
H-165.841 Comprehensive Health System Reform (Reaffirm HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 239 be amended by insertion and deletion on lines 36-38 to read as follows:

RESOLVED, That, should the Supreme Court of the United States declare the individual mandate unconstitutional, our AMA ~~advocate~~ evaluate House of Delegates Policy H-165.856, ~~for modification of~~

~~Sections 7 and 8, to decouple the~~ relating to our support for guaranteed issue ~~mandate from in the context of~~ the individual mandate, ~~alternatively coupling guaranteed issue to pre-existing coverage,~~ and recommend necessary policy changes at our 2012 Interim Meeting (Modify Current HOD Policy); and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the fifth resolve of Resolution 239 be amended by insertion and deletion on lines 9-11 to read as follows:

~~RESOLVED, That our AMA Board of Trustees immediately begin preparation for immediate grassroots advocacy of alternate federal health care reform options should either of these contingencies materialize,~~ the Supreme Court take action to strike any or all of the Patient Protection and Affordable Care Act (ACA), including development of materials or a report for review by our House of Delegates at our 2012 Interim Meeting.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 239 be adopted as amended in lieu of Resolutions 213 and 243.

HOD ACTION: Resolution 239 adopted as amended in lieu of Resolutions 213 and 243.

Resolution 213 asks (1) that our American Medical Association recognize that the provisions of the Patient Protection and Affordable Care Act (PPACA) increase the number of Medicaid beneficiaries by 25%, decrease funding for Medicare, lack a fix to the sustainable growth rate formula and lack tort reform for medical liability cases, and are not only financially unsustainable, representing unfunded mandates, but unfairly place the burden on physicians which will lead to the bankruptcy or dissolution of physician practices (New HOD Policy); and (2) that our AMA work for the revision of the flawed Patient Protection and Affordable Care Act to correct its deficiencies and replace it with a financially sustainable system which incorporates provisions that require fair contributions from all stakeholders. (Directive to Take Action). Resolution 239 asks (1) that our American Medical Association reaffirm the following House of Delegates Policies:

- ~ H-165.833 Amend the Patient Protection and Affordable Care Act (PPACA);
- ~ H-165.865 Principles for Structuring a Health Insurance Tax Credit;
- ~ H-165.985 Opposition to Nationalized Health Care;
- ~ H-165.920 Individual Health Insurance;
- ~ H-165.882 Improving Access for the Uninsured and Underinsured;
- ~ H-140.984 Physicians' Involvement in Commercial Ventures;
- ~ H-165.845 State Efforts to Expand Coverage to the Uninsured;
- ~ H-165.855 Medical Care for Patients with Low Incomes;
- ~ H-165.856 Health Insurance Market Regulation;
- ~ H-165.904 Universal Health Coverage;
- ~ H-165.852 Health Savings Accounts;
- ~ H-165.838 Health System Reform Legislation;
- ~ H-180.978 Access to Affordable Health Care Insurance through Deregulation of State Mandated Benefits; and
- ~ H-165.841 Comprehensive Health System Reform (Reaffirm HOD Policy)

and (2) that, should the Supreme Court of the United States declare the individual mandate unconstitutional, our AMA advocate for modification of House of Delegates Policy H-165.856, Section 8,

to decouple the guaranteed issue mandate from the individual mandate, alternatively coupling guaranteed issue to pre-existing coverage (Modify Current HOD Policy); (3) that our AMA reaffirm our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution (Reaffirm HOD Policy); (4) that our AMA, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system (Directive to Take Action); and (5) that our AMA Board of Trustees immediately begin preparation for immediate grassroots advocacy of alternate federal health care reform options should either of these contingencies materialize. (Directive to Take Action Resolution 243 asks that our American Medical Association support the repeal Public Law 111-148, the Patient Protection and Affordable Care Act. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolutions 213, 239, and 243. Many opposed Resolutions 213 and 243, stating that our House of Delegates has extensively discussed our position on the Patient Protection and Affordable Care Act (ACA), and has already invested many resources in our efforts to improve the law, and as such repeal is unwarranted. Others believed taking a stance against the ACA would not be supportive of our patients. On the other hand, your Reference Committee heard that some continue to be angered about our AMA's position on the ACA. Your Reference Committee agrees with those who testified in favor of modifying the ACA rather than repealing it, but extends our assurance to all physicians that their voices are being heard, and that our AMA is aggressively seeking to achieve changes in the ACA as directed by policy adopted through the collective will of our House of Delegates, including Policies H-165.833 and H-165.835, which direct our AMA to advocate for needed reforms of the defects of the ACA. Your Reference Committee further heard supportive testimony of Resolution 239, and those who testified expressed that our AMA needs to be prepared in the event the US Supreme Court strikes down the individual mandate. With regard to Resolution 239, your Reference Committee notes at the outset that Policy H-165.855, relating to Medicaid, is part of an AMA Council on Medical Service report that is being discussed for modification in Reference Committee A at this 2012 Annual Meeting. It would be technically difficult to reaffirm and modify the same policy in two different Reference Committees. Therefore, due to this technicality, your Reference Committee recommends deleting this policy from the list of policies to be reaffirmed under Resolution 239. Further, some testified in support of decoupling guaranteed issue from the individual mandate under current Policy H-165.856, as called for in Resolution 239. Your Reference Committee agrees that guaranteed issue is most feasible in the context of an individual mandate, and believes our policy should be amended in the event of a Supreme court reversal. Nevertheless, your Reference Committee is concerned that an appropriate procedural mechanism does not exist for amending policy due to a future event that may not occur. Rather, we believe that should the Supreme Court strike down the individual mandate, our AMA should review our policy on guaranteed issue and recommend specific language changes to be presented to our House of Delegates at our 2012 Interim Meeting. Your Reference Committee therefore recommends amending the second resolve of Resolution 239 to achieve this goal. Your Reference Committee also recommends an amendment to the last resolve in Resolution 239, which calls for our Board of Trustees to "immediately begin preparation for immediate grassroots advocacy of alternate federal health care reform options" should the Supreme Court strike down the individual mandate. Immediate grassroots advocacy may be premature since our Board will need time to assess the fall out of a Supreme Court reversal, and develop an appropriate strategy. Your Reference Committee acknowledges that such a reversal would create significant confusion among policymakers in terms of what the decision means and how to proceed, and this would be complicated by the uncertainty of the November elections. Further, your Reference Committee has learned that our AMA Council on Medical Service intends to develop a report for the 2012 Interim Meeting on health system reform alternatives in the event of a Supreme Court reversal. In this case, it would greatly benefit our Board of Trustees and House of Delegates to have the opportunity to first review, discuss, and provide input on this report. Due to the foregoing testimony and concerns, your Reference Committee recommends adoption of Resolution 239, as amended, in lieu of Resolutions 213 and 243.

(16) RESOLUTION 217 - EXPRESSION OF CONCERNS REGARDING
IMPLEMENTATION OF COOP PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 217 be amended by insertion and deletion on lines 26-29 to read as follows:

~~RESOLVED, That our American Medical Association offer advice or assistance to states in advocating that in crafting a response to the action of the Consumer Operated and Oriented Plan (COOP) advisory board and HHS ensure that new insurance issuers, including those with physician involvement, that enabled an established issuer of insurance to benefit from start-up loans, thus depriving New Yorkers of a new issuer. (Directive to Take Action)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 217 be adopted as amended.

HOD ACTION: Resolution 217 adopted as amended.

Resolution 217 asks that our American Medical Association offer advice or assistance in crafting a response to the action of the Consumer Operated and Oriented Plan (COOP) advisory board that enabled an established issuer of insurance to benefit from start-up loans, thus depriving New Yorkers of a new issuer. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 217. Your Reference Committee agrees it is important under the *Patient Protection and Affordable Care Act* to have enhanced coverage options and a more competitive insurance marketplace, including removing barriers to entry into the marketplace by new insurance issuers, especially those with physician involvement. Your Reference Committee believes, however, it is important for our AMA's assistance to be directed toward all states, not simply one particular state, as recommended in Resolution 217. A singular focus on New York, as requested in the testimony, is unnecessary because if our AMA's assistance is directed toward all states, this necessarily includes New York. Your Reference Committee, therefore, recommends adoption of Resolution 217, as amended.

(17) RESOLUTION 218 – PHARMACIST PRESCRIBING
RESOLUTION 240 – PHARMACIST PRESCRIBING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 218 be amended by deletion on lines 35-37 to read as follows:

~~RESOLVED, That our AMA oppose federal legislation that would create a new class of drugs which would enable the dispensing or refill of pharmaceutical agents without a current and valid prescription (New HOD Policy);~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 218 be adopted as amended in lieu of Resolution 240.

HOD ACTION: Resolution 218 adopted as amended in lieu of Resolution 240.

Resolution 218 asks (1) that our American Medical Association oppose federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry (New HOD Policy); (2) that our AMA oppose federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription (New HOD Policy); (3) that our AMA oppose federal legislation that would create a new class of drugs which would enable the dispensing or refill of pharmaceutical agents without a current and valid prescription (New HOD Policy); (4) that our AMA reaffirm AMA Policies D 405.991 and H 405.992 on the Definition of a Physician (Reaffirm HOD Policy); and (5) that our AMA oppose the inclusion of Doctors of Pharmacy (PharmD's) among those health professionals designated as a "Physician" by the Centers for Medicare and Medicaid services. (New HOD Policy)

Your Reference Committee heard extensive testimony related to Resolutions 218 and 240. Pharmacists are valuable members of the health care team. As represented in written and oral testimony from the pharmacy community, "the pharmacy profession occupies an important and longstanding position on the health care team as the medication expert to assist physicians and other providers in managing patients' medications in both inpatient and outpatient care settings." Your Reference Committee believes that when working as part of the physician-led health care team, pharmacists help to ensure that patients receive health care that is of the highest quality. Your Reference Committee, therefore, encourages our AMA to continue its dialogue with interested national pharmacy associations on how medicine and pharmacy can work together to achieve the triple aim of improving the quality of care received by our patients, while at the same time improving outcomes and lowering costs.

Your Reference Committee agrees with testimony that pharmacist education and training, however, are not equivalent to that of physicians (MDs and DOs). Your Reference Committee also agrees with testimony opposing pharmacists' ability to independently prescribe medications. Like many that testified, your Reference Committee is concerned that increasing the scope of practice of pharmacists, by allowing them to independently prescribe, goes against the ever-evolving national dialogue on health care delivery by fragmenting rather than integrating the management of patient care. Finally, your Reference Committee wants to acknowledge the testimony and concerns raised on the topic of immunizations. Your Reference Committee believes that the issues associated with immunizations warrant a separate conversation and, therefore, urges interested parties to submit a resolution addressing these issues at our 2012 Interim Meeting. These issues are complex and, therefore, warrant their own discussion by our House of Delegates. Your Reference Committee, therefore, recommends adoption of Resolution 218 as amended.

(18) RESOLUTION 219 - PHYSICIAN MANDATE TO CHECK PATIENTS CONTROLLED SUBSTANCE USAGE**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 219 be amended by insertion and deletion on lines 25-26 to read as follows:

RESOLVED, That our American Medical Association oppose any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) ~~do patient background checking~~ prior to prescribing controlled substances. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 adopted as amended.

Resolution 219 asks that our American Medical Association oppose any federal legislation that would require physicians to do patient background checking prior to prescribing controlled substances. (New HOD Policy)

Your Reference Committee heard testimony supportive of Resolution 219. There was general support for physicians checking appropriate and available prescription drug monitoring programs (PDMP) data, but there was overwhelming opposition to a federal mandate on this topic. This sentiment is in line with current Policy H-95.990(2)(D), which states, "Our AMA . . . encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances." Your Reference Committee recognizes that the prescription drug misuse and diversion problem needs a multi-prong solution, as stated in the resolution, and that adding additional administrative mandates and burdens to physician practices does not solve the problem. Your Reference Committee believes that PDMPs should be used to support clinical decision-making at the point-of-care as part of a physician's workflow, but not as a mechanism to trigger law enforcement actions. Finally, your Reference Committee agrees with a suggestion from the testimony asking for the removal of the term "background checking" from the resolution. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(19) RESOLUTION 221 - PRESCRIPTION MONITORING PROGRAM
CONFIDENTIALITY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 221 be amended by insertion and deletion on lines 32-33 to read as follows:

RESOLVED, That our American Medical Association: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; fully compliant with the Health Insurance Portability and Accountability Act (HIPAA); and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 221 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 221 be changed to read as follows:

PRESCRIPTION DRUG MONITORING PROGRAM
CONFIDENTIALITY**HOD ACTION: Resolution 221 adopted as amended with a change in title.**

Resolution 221 asks that our American Medical Association: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program to do so in a manner fully compliant with the Health Insurance Portability and Accountability Act (HIPAA); and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that a unlawful act or breach of the standard of care may have occurred. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 221. Your Reference Committee strongly agrees that prescription drug monitoring program (PDMP) data should be used for educational/clinical decision-making purposes, rather than as a tool for law enforcement, and should be afforded a stringent level of confidentiality. Further, your Reference Committee believes that state agencies whose primary purpose and mission is health care quality and safety are better locations for PDMPs rather than agencies whose primary mission is law enforcement. Further, the probable cause requirement in the third resolve establishes a sufficient safeguard for data with regard to law enforcement investigations or other legal investigations.

Your Reference Committee received testimony that called for clarification of the statutory/regulatory authority that protects such data. With this in mind, your Reference Committee agrees with the testimony suggesting that the resolution should refer to such data as “protected health information” and recommends that the resolution be amended to reflect this change. Finally, your Reference Committee recommends changing the title for consistency when referring to PDMPs. Therefore, your Reference Committee recommends adoption of Resolution 221, as amended.

(20) RESOLUTION 223 - PRESCRIPTION DRUG DIVERSION, MISUSE
AND ADDICTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 223 be amended by insertion on lines 7-8 to read as follows:

RESOLVED, That our AMA consider PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 223 be amended by insertion and deletion on line 12-13 to read as follows:

RESOLVED, That our AMA recommend that PDMP's be designed such that data is immediately available in real-time by when clinicians query the database and are considering a decision to prescribe a controlled substance (New HOD Policy); and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the fifth resolve of Resolution 223 be amended by deletion on line 20-25 to read as follows:

~~RESOLVED, That our AMA support amending the federal Controlled Substances Act to require all DEA registrants to obtain Continuing Medical Education training on the use of federally controlled substances, in order that practitioners will be better prepared to contribute to positive solution to the problems of prescription drug diversion and overdose deaths-- while asserting that DEA registrants should be permitted to select educational modules that are relevant to their practices and the classes of medications they frequently prescribe (New HOD Policy) and be it further~~

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 223 be adopted as amended.

HOD ACTION: Resolution 223 adopted as amended.

Resolution 223 asks that: our American Medical Association: (1) support permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions (New HOD Policy); (2) consider PDMP data to be health information, and thus protected from release outside the healthcare system unless there is a specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information (New HOD Policy); (3) recommend that PDMP's be designed such that data is available in real-time by clinicians considering a decision to prescribe a controlled substance (New HOD Policy); (4) recommend that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries (New HOD Policy); (5) support amending the federal Controlled Substances Act to require all DEA registrants to obtain Continuing Medical Education training on the use of federally controlled substances, in order that practitioners will be better prepared to contribute to positive solution to the problems of prescription drug diversion and overdose deaths-- while asserting that DEA registrants should be permitted to select educational modules that are relevant to their practices and the classes of medications they frequently prescribe (New HOD Policy) and (6) promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony regarding Resolution 223. Your Reference Committee generally supports the resolution and recognizes it as consistent with our AMA recommendations to Congress, the Administration, and states to combat prescription drug abuse and diversion. We recognize that our AMA has offered strong support for H.R. 866, the *National All Schedules Prescription Electronic Reporting Reauthorization Act of 2011* (NASPER 2011), which would establish and modernize existing state-based prescription drug monitoring programs (PDMP) and provide physicians with a basic tool to make treatment determinations based on patient-specific needs, and our AMA continues to urge Congress to provide full appropriations for this legislation.

After discussion, your Reference Committee agreed to make the language in the second resolve consistent with amended Resolution 221 regarding the confidentiality of PDMP data by calling it "protected health information." Your Reference Committee also recommends including a reference to possible HIPAA exceptions to the release of the data because the current resolution language could place a physician in a difficult position when there is a legitimate law enforcement request for information under federal or state law and the patient has not provided an authorization. Further, the resolution seeks data availability in real-time in the third resolve, but your Reference Committee feels that this is too broadly worded and has a number of meanings, so it recommends editing that resolve for clarity. Finally, your Reference Committee recommends deletion of the fifth resolve because it agrees with the testimony contending that CME should continue to be a state-based activity. Therefore, your Reference Committee recommends adoption of Resolution 223, as amended.

(21) RESOLUTION 226 - THREE-DAY PAYMENT WINDOW RULE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 226 be amended by insertion and deletion on lines 32-35 to read as follows:

That our AMA work with other appropriate stakeholders to continue seeking a delay or modification of the three-day payment window rule; encourage CMS to clarify to whom and how this rule applies; and communicate the specifics about this rule to the physician community with the American Hospital Association to develop a protocol to ensure proper billing of both the facility claim and the claim for professional services during the 3-Day Payment Window should the AMA be unsuccessful in overturning the applicable rules/legislation. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 226 be adopted as amended.

HOD ACTION: Resolution 226 adopted as amended.

Resolution 226 asks that our American Medical Association work with the Centers for Medicare & Medicaid Services (CMS) to request a further delay in implementation of the 3-day Payment Window rule beyond the current delay of July 1, 2012 (Directive to Take Action); (2) that our AMA thoroughly investigate all legislative and regulatory actions taken by Congress and CMS associated with the 3-Day Payment Window during this delay and determine whether additional legislative and/or regulatory actions are warranted to include overturning the current Rule (Directive to Take Action); (3) that our AMA work with the American Hospital Association to develop a protocol to ensure proper billing of both the facility claim and the claim for professional services during the 3-Day Payment Window should the AMA be unsuccessful in overturning the applicable rules/legislation. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 226, and acknowledges that through our AMA advocacy activities, we achieved a six-month delay in implementation of the three-day payment window rule through July 1, 2012. We understand our AMA is continuing to work with other affected stakeholders in advocating for a further delay in implementation of this rule based on evidence that there is widespread confusion about which hospitals and physicians are affected by the rule and the fact that CMS does not yet have in place all the mechanisms needed to enforce the provision. Based on these concerns, your Reference Committee believes it is important for our AMA to continue advocating that CMS further delay implementation of the three-day payment window rule. Your Reference Committee is concerned, however, about calling for our AMA to work with the AHA to develop a protocol to ensure proper billing during the three-day payment window. We believe that developing this protocol may not be the proper role for our AMA since compliance with the three-day payment rule would vary according to the characteristics of individual practices and their relationship with the hospital owner. As a result, creating such a protocol may be better accomplished at the local level. Your Reference Committee agrees that it would be more appropriate and effective for our AMA to work with other appropriate stakeholders to continue seeking a delay or modification in the provision; encourage CMS to clarify to whom and how the three-day payment rule applies; and communicate the specifics about this rule to the physician community. Your Reference Committee therefore recommends adoption of Resolution 226, as amended.

(22) RESOLUTION 228 - CLINICAL DECISION SUPPORT AND MALPRACTICE RISK

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 228 be amended by insertion on line 5 to read as follows:

RESOLVED, That our American Medical Association advocate in interested states for legislation that would create a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 228 be amended by insertion on line 9 to read as follows:

RESOLVED, That our AMA communicate to governmental authorities in interested states that patients, physicians, hospitals, and the government will all lose out if a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package is not developed. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 228 be adopted as amended.

HOD ACTION: Resolution 228 adopted as amended.

Resolution 228 asks that our American Medical Association advocate for legislation that would create a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision

support software package (Directive to Take Action); and (2) that our AMA communicate to governmental authorities that patients, physicians, hospitals, and the government will all lose out if a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package is not developed. (Directive to Take Action)

Your Reference Committee considered testimony on Resolution 228. The participants expressed ongoing concern regarding the current medical liability system's effects on the practice of medicine and the need to protect physicians from meritless liability lawsuits. Your Reference Committee considered testimony that physicians should be protected from liability when they follow certain guidelines such as the use of a consensus-based drug-drug interaction list in their clinical decision support software package, but that such guidelines should not be mandatory or constitute the standard of care for legal purposes. Based on this discussion, your Reference Committee recommends that the language be amended to call on our AMA to work with interested states on the creation of safe harbors to provide liability relief related to the use of a consensus-based drug-drug interaction list. Such efforts should comply with current AMA policy to ensure that physician use of such a tool would be voluntary and would not establish the standard of care for legal purposes. Therefore, your Reference Committee recommends that Resolution 228 be adopted, as amended.

(23) RESOLUTION 231 - ESTABLISHMENT OF LIMITED POPULATION ANTIBACTERIAL DRUG APPROVAL PATHWAY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 231 be amended by insertion and deletion on lines 47-48 to read as follows.

RESOLVED, That our American Medical Association support establishment of the Limited Population Antibacterial Drug (LAPD) mechanism to provide a predictable and feasible Food and Drug Administration approval pathway for pharmaceutical companies seeking to develop antibacterial drugs to treat serious and life-threatening infections where there is a lack of insufficient, or satisfactory therapeutic options ~~exist~~, through legislative or regulatory means (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 231 be adopted as amended.

HOD ACTION: Resolution 231 adopted as amended.

Resolution 231 asks (1) that our American Medical Association support establishment of the Limited Population Antibacterial Drug (LAPD) mechanism to provide a predictable and feasible Food and Drug Administration approval pathway for pharmaceutical companies seeking to develop antibacterial drugs to treat serious and life-threatening infections where insufficient, satisfactory therapeutic options exist, through legislative or regulatory means (New HOD Policy); and (2) that should the LPAD be established, our AMA shall work with IDSA, other medical societies, and the health care community to educate providers about LPAD products, including their benefits and risks. (Directive to Take Action)

Your Reference Committee heard supportive testimony of Resolution 231. Your Reference Committee strongly believes that manufacturers need regulatory incentives to promote the next generation of antibiotics for targeted populations that would not otherwise have antibiotics approved due to burdensome regulatory hurdles. Your Reference Committee believes that some very minor edits are

needed to clarify the resolve. Therefore, your Reference Committee recommends adoption of Resolution 231 as amended.

- (24) RESOLUTION 233 - CMS SUNSHINE ACT - BAD FOR PATIENTS AND PHYSICIANS AND GOOD FOR ACCOUNTANTS, BUREAUCRATS AND LAWYERS
RESOLUTION 238 – PHYSICIAN PAYMENTS SUNSHINE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 233 be adopted in lieu of Resolutions 233 and 238.

HOD ACTION: Substitute Resolution 233 adopted in lieu of Resolutions 233 and 238, with a change in title.

Resolved, That our American Medical Association continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by CMS.

Resolved, That our AMA recommend to the CMS that a physician comment section be included on the “Physician Payments Sunshine Act” public database. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Substitute Resolution 233 be changed to read as follows:

PHYSICIAN PAYMENTS SUNSHINE ACT

Resolution 233 asks (1) that our American Medical Association lobby Congress to repeal the Sunshine Act (Directive to Take Action); (2) that our AMA continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services. (Directive to Take Action) Resolution 238 asks that our American Medical Association recommend to the Centers for Medicare & Medicaid Services that a physician comment section be included on the “Physician Payments Sunshine Act” public database. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 233 and Resolution 238. The testimony expressed general support for the resolutions and concern with implementation of the Sunshine Act. Your Reference Committee discussed at length the resolutions and concluded that a substitute resolution is the best option on this issue.

The Sunshine Act was included as part of the ACA, and our AMA was able to secure several modifications to this provision before it was enacted. In an era of transparency in the health care system, AMA efforts to repeal the Sunshine Act could be misconstrued as an effort to stall transparency efforts. With this in mind, your Reference Committee recommends deleting the first resolve from Resolution 233. However, your Reference Committee recommends that the second resolve from Resolution 233 and the only resolve from Resolution 238 be included in the substitute resolution and that they be adopted. Our AMA is actively communicating our concerns about the implementation of the Sunshine Act to the government and is working to change the current proposed implementation plan, so it better reflects AMA recommendations, including that manufacturers remain responsible for reporting and that the reporting must be accurate. Your Reference Committee also agrees with the resolve in Resolution 238 that physicians should have an opportunity to provide explanatory notes regarding all reporting done by manufacturers to the government and the public as required by the Sunshine Act. Therefore, your

Reference Committee recommends adoption of Substitute Resolution 233 in lieu of Resolutions 233 and 238.

(25) RESOLUTION 234 - OPPOSE LEGISLATION TO EXEMPT CIGARS FROM FDA OVERSIGHT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 234 be amended by insertion and deletion on line 36 to read as follows:

That our AMA strongly oppose legislation H.R. 1639/S.1461 which would undermine the Food and Drug Administration's authority to regulate tobacco products; (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 234 be amended by insertion and deletion on line 2 to read as follows:

That our AMA encourage state medical associations to contact their state delegations to oppose legislation H.R. 1639/S.1461 which would undermine the Food and Drug Administration's authority to regulate tobacco products. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 234 be adopted as amended.

HOD ACTION: Resolution 234 adopted as amended.

Resolution 234 asks (1) that our American Medical Association strongly opposes H.R. 1639/S.1461 which would undermine the Food and Drug Administration's authority to regulate tobacco products (New HOD Policy); and (2) that our AMA encourage state medical associations to contact their state delegations to oppose H.R. 1639/S.1461.

Your Reference Committee heard testimony in support of Resolution 234. Your Reference Committee agrees with those who expressed opposition to legislation that would undermine the Food and Drug Administration's authority to regulate tobacco products by exempting many types of cigars from FDA authority. However, since AMA policy does not typically refer to specific legislation, your Reference Committee recommends adoption of Resolution 234, as amended.

(26) RESOLUTION 236 - EVALUATION OF ICD-11 AS NEW DIAGNOSTIC CODING SYSTEM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 236 be amended by insertion and deletion on lines 20-22 to read as follows:

RESOLVED, That our American Medical Association evaluate the feasibility of moving from ICD-9 to preliminary versions of ICD-11 as

~~an alternative to ICD-10 a new diagnostic coding system and report back to the House of Delegates in June 2013 as to its potential impact on a physician's practice. (Directive to Take Action)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 236 be adopted as amended.

HOD ACTION: Resolution 236 adopted as amended.

Resolution 236 asks that our American Medical Association evaluate preliminary versions of ICD-11 as a new diagnostic coding system and report back to the House of Delegates in June 2013 as to its potential impact on a physician's practice. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 236. Those who testified indicated that the implementation of ICD-10 coding will create unnecessary and significant financial and workflow disruptions for physicians, especially at a time when physicians are in various stages of trying to implement electronic health records into their practices. Your Reference Committee also heard that the next iteration of ICD, ICD-11, is on the horizon so it may be less burdensome of a transition for physicians if they wait and move from ICD-9 to ICD-11 at a much later date. Resolution 236 calls for our AMA to evaluate the impact ICD-11. Your Reference Committee agrees with those that testified, but is concerned ICD-11 may not be developed enough yet to allow a thorough and comprehensive evaluation. Your Reference Committee therefore believes it would be most prudent for our AMA to explore the feasibility of moving from ICD-9 to ICD-11, as an alternative to ICD-10, with a report back to our House of Delegates. Therefore your Reference Committee recommends adoption of Resolution 236, as amended.

(27) RESOLUTION 242 - PRACTICE DRIFT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 242 be amended by insertion and deletion on lines 26 and 27 to read as follows:

RESOLVED, That our American Medical Association study the issue of physician drift and report back ~~at the 2013 AMA Annual Meeting~~ with recommendations to ~~include, but not limit, to:~~ (1) ~~address~~ whether AMA policy or the AMA Code of Ethics should be modified, and (2) ~~develop~~ model language, if appropriate, to amend state Truth in Advertising laws to ensure patients are properly informed when making healthcare decisions about a physician's training. (Directive To Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 242 be adopted as amended.

HOD ACTION: Resolution 242 adopted as amended.

Resolution 242 asks that our American Medical Association study the issue of physician drift and report back at the 2013 AMA Annual Meeting with recommendations to: (1) address whether AMA policy or the AMA Code of Ethics should be modified, and (2) develop model language, if appropriate, to amend state Truth in Advertising laws to ensure patients are properly informed when making healthcare decisions about a physician's training. (Directive to Take Action)

Your Reference Committee appreciates the authors of Resolution 242 for bringing the issue of “practice drift” to our attention. We concur with the majority of the testimony that the issues related to practice drift require additional study. There are many issues that are associated with practice drift. Some of those who testified did not believe the issue of practice drift ought to be tied to our AMA’s Truth in Advertising campaign, which seeks to add transparency to our health care system by requiring all health care providers to identify to their patients, whether in person or in advertising, the level of their licensure. Others testified that our AMA should study whether the issue of practice drift ought to be addressed by our AMA Code of Ethics. As a result, your Reference Committee recommends that our AMA study this issue from a comprehensive perspective, including, but not limited to the issues set forth in the resolution, and come back to our House of Delegates with recommendations for AMA policy related thereto. Your Reference Committee also recommends a minor amendment to reflect that reports are typically reported back to our House of Delegates within the year. Your Reference Committee, therefore, recommends adoption of Resolution 242, as amended.

(28) RESOLUTION 207 - CLEAR AND CONVINCING EVIDENCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 207 be referred.

HOD ACTION: Resolution 207 referred.

Resolution 207 asks (1) that our American Medical Association support the application of a clear and convincing evidence standard to all medical liability cases (New HOD Policy); and (2) that our AMA develop model state malpractice legislation that would include the principle of clear and convincing evidence for utilization in state malpractice actions. (Directive to Take Action)

Your Reference Committee heard testimony on Resolution 207 that is supportive of reforming the medical liability system and reducing the practice of defensive medicine. Your Reference Committee also compliments the author for bringing this resolution to the House of Delegates for consideration. Your Reference Committee discussed that AMA policy supports the use of the clear and convincing standard in demands for punitive damages and in medical board licensure actions, but does not have policy calling for the use of the clear and convincing standard in all medical liability claims. Further, some states use the clear and convincing standard for medical liability claims related to health care provided in an emergency department, but no state uses the standard for all medical liability claims. After discussion, your Reference Committee still has several outstanding questions regarding: how such a shift to the clear and convincing standard for all medical liability claims would affect patients who did experience harm and have a legitimate claim to compensation; how would such a shift affect other components of the current legal system; how has the standard worked in states that have enacted it for emergency care; and how would AMA advocacy for the clear and convincing standard in all medical liability claims be received by states that have already enacted proven reforms and how would it affect those reforms. Therefore, your Reference Committee recommends referral, so that our AMA can study this issue and report back on the implications of such a change to the current litigation system.

(29) RESOLUTION 222 - WORK-RELATED ABUSES OF IMG PHYSICIANS
WORKING UNDER THE CONRAD 30 PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 222 be referred.

HOD ACTION: Resolution 222 referred.

Resolution 222 asks (1) that our American Medical Association develop a mechanism by which physicians working under the Conrad-30 program encountering work-related abuses may report this information directly to our American Medical Association without fear of retribution for purposes of data collection for advocacy support (Directive to Take Action); (2) that our AMA aggressively investigate reports of possible work-related abuses encountered by IMG physicians under the Conrad-30 program (Directive to Take Action); and (3) that our AMA advocate for legislative and regulatory changes to the Conrad-30 program if deemed necessary to prevent work-related abuses of IMG physicians. (Directive to Take Action)

Your Reference Committee heard testimony on Resolution 222 from those who expressed serious concern about international medical graduates (IMGs) with Conrad-30 visa waivers who suffer from work-related abuses and have no mechanism to report such abuses. Many of those who testified supported referral of this resolution to address this very complex issue. Your Reference Committee shares the concerns expressed about abuse of IMGs and believes they deserve a mechanism for reporting abuses and seeking a remedy. Your Reference Committee also agrees with those who testified that the complex issues involved must be explored and addressed by our AMA. We believe, however, it is not an appropriate role for our AMA to act as an investigator and enforcer in these types of abuse-related situations. Your Reference Committee, therefore, recommends that Resolution 222 be referred.

(30) RESOLUTION 225 - SEPARATE PALLIATIVE DEATHS FROM THE MORTALITY STATISTICS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 225 be referred.

HOD ACTION: Resolution 225 referred.

Resolution 225 asks that our American Medical Association work with the Centers for Medicare & Medicaid Services to develop a separate mortality statistic for hospital patients receiving comfort care so that mortality data reported in the quality reporting sites depicts the actual quality of care delivered. (Directive to Take Action)

Your Reference Committee heard testimony on Resolution 225 expressing support for the general concept of improved quality data reporting, particularly with mortality statistics. However, your Reference Committee agrees with testimony that the concept of a separate palliative death measurement needs further study and definition before our AMA proceeds in this regard, particularly with advocacy to external organizations. Your Reference Committee, therefore, recommends referral of Resolution 225.

(31) RESOLUTION 230 - REDUCING ECONOMIC DAMAGES AS A DRIVER OF MEDICAL LIABILITY CASES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 230 not be adopted.

HOD ACTION: Resolution 230 not adopted.

Resolution 230 asks that our American Medical Association advocate for legislation and regulation to provide Medicare and Medicaid health benefits for adults and children disabled in an encounter subject to a medical malpractice award or settlement – so that these medical payments will be both guaranteed and secure and will no longer need to be litigated nor become the obligation of the states (Directive to Take Action); (2) that our AMA advocate for modification of the collateral source rule to allow for the defendant to introduce evidence of medical payments made or expected to be made on behalf of plaintiff for past

and future medical expenses (Directive to Take Action); and (3) that our AMA advocate for legislation or regulation to repeal that portion of Medicare as Secondary Payer Manual, section 10.6 so that Medicare will no longer be secondary to a medical liability insurance settlement/award and that under current law makes such award 'lien-able. (Directive to Take Action)

Your Reference Committee heard limited testimony in support of Resolution 230. Your Reference Committee understands the importance of this issue and agrees that the resolution is a novel approach to medical liability reform. However, your Reference Committee has several concerns on the first resolve. First, it could be perceived by the public that physicians are seeking to shift the financial burden of medical errors to the federal government. Second, in a deficit reduction environment, this resolve would be very difficult to legislate. Third, states with effective medical liability reform laws could be concerned about the impact of the federal government assuming this duty. Finally, there were concerns about the effects of this provision on the liability system as a whole, i.e., would there be unintended consequences, and would it lead to more or fewer lawsuits. Regarding the second resolve, our AMA already has policy in this regard and includes collateral source reform in our advocacy efforts. Finally, your Reference Committee discussed that the final resolve would again be a very difficult advocacy fight in a deficit reduction environment. Based on this discussion and these concerns, your Reference Committee again commends the author for an innovative approach on the liability issue, but recommends that Resolution 230 not be adopted.

(32) RESOLUTION 205 - REFORM THE US FARM BILL TO IMPROVE US
PUBLIC HEALTH AND FOOD SUBSTANTIABILITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-150.978 be reaffirmed in lieu of Resolution 205.

HOD ACTION: HOD Policy D-150.978 reaffirmed in lieu of Resolution 205.

Resolution 205 asks (1) that our American Medical Association actively lobby for reform of the US Farm Bill to reflect pre-existing AMA policy goals (Directive to Take Action); and (2) that our AMA recommend US Farm Bill budget cuts be directed through a newly created advisory board that includes, among other stakeholders, physicians and public health officials. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 205. Your Reference Committee agrees it is important to support healthier diets and lifestyles. However, while it is feasible and laudable to lobby for individual programs that promote public health and nutrition, your Reference Committee is concerned that "actively lobbying" to reform the massively comprehensive farm bill would be extremely resource-intensive, without a proportionate return on investment, and therefore may undermine our AMA's efforts to lobby for individual public health and nutrition programs. Further, the second resolve of Resolution 205 is particularly problematic because it calls for an independent advisory board to determine budget cuts. This runs counter to our advocacy efforts to repeal the Independent Payment Advisory Board (IPAB), a similar structure that our AMA opposes because it is an independent board that makes decisions separate from Congress, and therefore is not accountable. The sponsors of Resolution 205 proposed an amendment to lobby for the creation of an advisory board, including physicians and public health officials, to advise on the impact of the US farm bill. Your Reference Committee acknowledges the importance of reviewing the impact of U.S. farm bill policies, but believes existing AMA policy appropriately covers this goal. In fact, D-150.978 directs our AMA to: encourage the development of a healthier food system through the US Farm Bill and other federal legislation; and consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. Your Reference Committee, therefore, recommends reaffirmation of Policy D-150.978 in lieu of Resolution 205.

D-150.978 Sustainable Food

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11)

(33) **RESOLUTION 209 - SUPPORT OF THE LEGAL RIGHT OF CIVIL MARRIAGE BETWEEN ANY TWO CONSENTING ADULTS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policy H-65.973 be reaffirmed in lieu of Resolution 209.

HOD ACTION: HOD Policy H-65.973 reaffirmed in lieu of Resolution 209.

Resolution 209 asks (1) that our American Medical Association recognize that denying civil marriage based on sexual orientation is discriminatory and contributes to health care disparities affecting same-sex households (New HOD Policy); (2) that our AMA support the legal recognition of civil marriage between any two consenting adults (New HOD Policy); (3) that our AMA oppose laws that restrict the rights, benefits, privileges, and responsibilities granted to married couples based on one's gender and sexual orientation (New HOD Policy); and (4) that our AMA discuss these measures for support and adoption at the 2012 Annual Meeting. (Directive to Take Action)

Your Reference Committee heard testimony on this resolution that offered opinions on both sides of this highly-charged debate. There was testimony in support of marriage equality, and there was testimony urging our AMA to avoid debates over social issues and focus on the health care needs of patients. While your Reference Committee appreciates both points of view, after lengthy discussion, we believe the best course of action for our AMA is to reaffirm current Policy H. 65.973, which states in part that "Our American Medical Association . . . recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families . . ." This policy was adopted at our Annual Meeting in 2011 based on Board of Trustees Report 15 which resulted from debates at both A-10 and I-10. Your Reference Committee also discussed the possibility of referral based on the on-site testimony, but believes that this issue has been fully vetted by our Board of Trustees and the House of Delegates in recent years, so your Reference Committee maintains its recommendation of reaffirmation. Therefore, your Reference Committee recommends that Policy H-65.973 be reaffirmed in lieu of Resolution 209.

H-65.973 Health Care Disparities in Same-Sex Partner Households

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households. (CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11)

(34) RESOLUTION 237 - PENALTIES FOR NON-ADOPTION OF HIT TECHNOLOGY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-478.991, H-478.993 and H-478.994 be reaffirmed in lieu of Resolution 237.

HOD ACTION: HOD Policies H-478.991, H-478.993 and H-478.994 reaffirmed in lieu of Resolution 237.

Resolution 237 asks that our American Medical Association oppose any regulation requiring financial penalties for physicians who do not adopt these technologies. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 237. Those who testified indicated that physicians are facing technological, financial, administrative, and other challenges in meeting federal requirements for the use of health information technology (HIT) and electronic health records (EHRs). Some testified, however, that our AMA should oppose legislation, and not simply any regulation, requiring penalties for physicians who do not adopt HIT and EHRs in their practices, as called for in the resolution. Your Reference Committee notes that our AMA already has extensive policy opposing these types of legislative penalties, and therefore recommends reaffirmation of Policies H-478.991, H-478.993, and D-478.994 in lieu of Resolution 237.

H-478.991 Federal EMR and Electronic Prescribing Incentive Program

Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; and (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10)

H-478.993 Implementing Electronic Medical Records

It is the policy of our AMA that public and private insurers should not require the use of electronic medical records. (Sub. Res. 707, A-06; Reaffirmation A-07)

D-478.994 Health Information Technology

Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; and (3) support initiatives to ensure interoperability among all HIT systems. (Res. 723, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed: Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11)

(35) RESOLUTION 241 - PATIENT PROTECTION AND AFFORDABLE CARE ACT NONDISCRIMINATION LANGUAGE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-35.968 be reaffirmed in lieu of Resolution 241.

HOD ACTION: Resolution 241 adopted as amended.

RESOLVED. That our AMA report back at I-12 on the specific activities and any outcomes that have occurred regarding AMA Policy H-35.968.

Resolution 241 asks that our American Medical Association promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's "Non-Discrimination in Health Care" language, including direct collaboration with other interested components of organized medicine. (Directive to Take Action)

Your Reference Committee heard testimony on Resolution 241 and agrees with those who testified that the so-called "non-discrimination clause" of the Affordable Care Act (ACA) is of great concern. Your Reference Committee agrees with testimony that this language is vague and that it is important to work to resolve the scope of practice problems that can result from this clause. Further, your Reference Committee agrees that the term "non-discrimination" is confusing and misplaced. While your Reference Committee is clearly concerned with this language, it feels compelled to point out that our AMA has existing policy that is almost identical to the resolve of Resolution 241. Specifically, adopted at our 2010 Annual Meeting, H-35.968 states that

"[o]ur AMA will work to repeal new Public Health Service Act Section 2706, so-called provider "Non-Discrimination in Health Care," as enacted in PPACA, through active direct and grassroots lobbying of and formal AMA written communications and/or comment letters to the Secretary of Health and Human Services and Congressional leaders and the chairs and ranking members of the House Ways and Means and Energy and Commerce and Senate Finance Committees."

It is your Reference Committee's understanding that our AMA has and will continue to advocate before Congress and the Administration to achieve needed reforms of the many defects in the ACA. Further, our AMA's state legislative unit continues to work with state and national medical specialty societies to address the "non-discrimination clause" as it arises in the state legislative and/or regulatory arenas across the country. Therefore, your Reference Committee recommends reaffirmation of existing policy in lieu of Resolution 241.

H-35.968 Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws

Our AMA will work to repeal new Public Health Service Act Section 2706, so-called provider "Non-Discrimination in Health Care," as enacted in PPACA, through active direct and grassroots lobbying of and formal AMA written communications and/or comment letters to the Secretary of Health and Human Services and Congressional leaders and the chairs and ranking members of the House Ways and Means and Energy and Commerce and Senate Finance Committees.

Reference Committee C (Medical Education)

(1) BOARD OF TRUSTEES REPORT 16 - ENHANCING THE FUNCTION OF THE LIAISON COMMITTEE ON MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in AMA Board of Trustees Report 16 be adopted and the remainder of the report be filed.

HOD ACTION: AMA Board of Trustees Report 16 adopted and the remainder of the report filed.

Board of Trustees Report 16, Enhancing the Function of the Liaison Committee on Medical Education (LCME), summarizes the work and recommendations of the LCME Joint Task Force, convened by our AMA and the Association of American Medical Colleges (AAMC) to explore a broad range of issues and strategies related to the LCME's current structure, function and work processes. In keeping with the historic precedent that the AMA House of Delegates assigns to the Council on Medical Education responsibility for oversight of the LCME, the Board of Trustees recommends that the following recommendations be adopted: 1) That our AMA support a formal recognition of the organizational relationships among the AMA, the AAMC, and the LCME through a memorandum of understanding; 2) That, consistent with United States Department of Education regulations and its historic role, the LCME should remain the final decision-making authority over accreditation matters, decisions, and policies for undergraduate medical education leading to the MD degree; 3) That the LCME have final decision-making authority regarding the establishment, adoption and amendment of accreditation standards, through a defined process that allows the sponsors an opportunity to review, comment, and recommend changes to, and refer back for further consideration, new or amended standards proposed by the LCME; 4) That a new entity be formed to support communications, flexibility and planning among the AMA, the AAMC and the LCME on medical school accreditation, with membership, authority and additional parameters to be defined within the new memorandum of understanding; 5) That AMA Council on Medical Education be the entity within the AMA to determine policy relating to the organization or structure of the LCME; 6) That AMA Policy H-295.882, "Proposed Consolidation of Liaison Committee on Medical Education" be modified to read as follows: "(1) Our AMA reaffirms its ongoing commitment to excellence in medical education and its continuing responsibility for accreditation of undergraduate medical education. ~~(2) Any proposed changes in the role of the AMA in the organization or structure of the LCME should be considered matters of AMA policy.~~

Your Reference Committee heard strong support for this report and for our AMA Council on Medical Education's continued role in medical school program accreditation via the Liaison Committee on Medical Education (LCME). The proposed recommendations would help optimize the effectiveness and integrity of the LCME and better define, streamline and strengthen the relationship between the LCME's sponsoring organizations, our AMA and the Association of American Medical Colleges (AAMC). Accordingly, your Reference Committee urges adoption of this report.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 3 - UPDATE ON INTERPROFESSIONAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: CME Report 3 referred with report back.

Council on Medical Education Report 3, Update on Interprofessional Education, provides an update on the current status of interprofessional education (IPE) for physicians-in-training and highlights the successes that have been achieved. This report recommends 1) That our AMA support the concept that medical education should prepare students for practice in interprofessional teams. 2) That our AMA encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners. 3) That our AMA encourage the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to facilitate the incorporation of interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education. 4) That our AMA encourage the development of competencies for interprofessional education that are applicable to and appropriate for each group of learners.

Your Reference Committee heard limited but supportive testimony in support of this report. The idea that students from a variety of health professions should train together has existed for many years. However, it is only relatively recently that the concept of interprofessional education (IPE) has been crystallized and has received widespread endorsement as a means to prepare physicians and other members of the health care team for practice in a collaborative care model. IPE is an important element in preparing physicians for practice in the evolving health care system. The report's recommendations encourage integration of IPE in an appropriate way into educational offerings for medical students and trainees. This will encourage better teamwork, leading to improved communication, more efficiency and a higher quality of care for our patients. For these reasons, your Reference Committee recommends adoption of this report.

- (3) COUNCIL ON MEDICAL EDUCATION REPORT 5 –
ADVANCE TUITION PAYMENT REQUIREMENTS FOR
INTERNATIONAL STUDENTS ENROLLED IN US MEDICAL SCHOOLS
(RESOLUTION 312-A-10)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: CME Report 5 adopted and the remainder of the report filed.

Resolution 312-A-10, "Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools," introduced by the Medical Student Section (MSS), asked that our AMA discourage US medical schools from requiring international students to pay more than a single term's tuition at each billing period, and encourage schools to instead allow international students to pay tuition in the same manner as US citizens and US residents.

Council on Medical Education Report 5, Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools, presents an overview of data on international student applications and matriculation to medical school; reviews the cost of medical education and tuition requirements for international students by US medical schools; and discusses tuition requirement practices at osteopathic medical schools. The report asks: 1) That our American Medical Association (AMA) support the autonomy of medical schools to determine optimal tuition requirements for international students. 2) That our AMA encourage medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance. 3) That our AMA support the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR®). 4) That our AMA encourage medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

Your Reference Committee heard limited but supportive testimony in favor of this report. The report's recommendations should help improve the transparency of information shared with international applicants to U.S. medical schools while allowing each school to maintain its autonomy. Testimony was submitted asking that the current practices of medical schools be deemed "excessive," but your Reference Committee feels that this addition would be unnecessary and is not supported by the data referenced in the body of the report. We would urge adoption of the report as written.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 8 - EVALUATION OF INCOME-CONTINGENT MEDICAL EDUCATION LOANS (RESOLUTION 306-A-11)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: CME Report 8 adopted and the remainder of the report filed.

Resolution 306-A-11, submitted by the Medical Student Section and referred to the Board of Trustees, asked that our AMA "1) Study the feasibility of medical school-initiated income-contingent loans, including the Strategic Alternative for Funding Education proposal, as a mechanism to alleviate medical education debt, and 2) Sponsor a national request for proposals aimed at recruiting additional innovative initiatives focused on alleviating medical student debt, and support the best proposal(s), following feasibility studies, at the highest lobbying and legislative priority." Council on Medical Education Report 8, Evaluation of Income-Contingent Medical Education Loans, asks that our AMA reaffirm AMA Policy H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt."

Your Reference Committee heard unanimous testimony in support of this report. This report, and its proposed recommendations, would add to our AMA's existing (and substantial) policy on this topic and reflect the association's commitment to a 360-degree review of all available options for reducing medical student debt. For these reasons, your Reference Committee recommends adoption of this report.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 9 - MEDICAL SCHOOL INTERNATIONAL SERVICE-LEARNING OPPORTUNITIES AND GLOBAL HEALTH EDUCATION (RESOLUTION 307-A-11 AND RESOLUTION 310-A-11)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: CME Report 9 adopted and the remainder of the report filed.

Resolution 307-A-11, introduced by the Medical Student Section (MSS), asked that our AMA work with the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and other relevant organizations "to ensure that medical school international service-learning opportunities are structured to contribute meaningfully to medical education and that medical students are appropriately prepared for these experiences;" and "to ensure that medical students participating in international service-learning opportunities are held to the same ethical and professional standards as students participating in domestic service-learning opportunities." As concerns were raised about the educational quality of international electives and the need for more uniform

standards, this item was referred for further study. Similarly, Resolution 310-A-11, introduced by the Medical Student Section, asked that our AMA “recognize the importance of global health education for medical students” and “encourage medical schools to include global health learning opportunities in their medical education curricula.” This item was also referred for study.

Council on Medical Education Report 9, Medical School International Service-Learning Opportunities and Global Health Education, recommends: 1) That our American Medical Association (AMA) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in international electives are held accountable to the same ethical and professional standards as students participating in domestic service-learning opportunities. 2) That our AMA work with the AAMC to ensure that international electives provide measureable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods. 3) That our AMA communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives.

Your Reference Committee heard unanimous support for this report. The involvement of our AMA, Association of American Medical Colleges (AAMC) and other organizations in a coordinated approach to global health education could increase both the quantity of medical students taking advantage of such opportunities as well as the quality of the programs themselves. These service-learning and global health experiences should be safe, educational, and meet the needs of the surrounding community in an ethical and professional manner; the recommendations put forth in this report would help make this ideal a reality. Accordingly, we recommend adoption of this report.

- (6) COUNCIL ON MEDICAL EDUCATION REPORT 11 - IMPACT OF MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, AND MAINTENANCE OF LICENSURE ON THE PHYSICIAN WORKFORCE (RESOLUTION 328-A-11)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 11 be adopted and the remainder of the report be filed.

HOD ACTION: CME Report 11 adopted and the remainder of the report filed.

Resolution 328-A-11, Impact of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL) on the Physician Workforce, introduced by the Young Physicians Section, was referred for study. This resolution asked our AMA to actively work with stakeholder organizations to study the potential impact of MOC, OCC, and MOL on the physician workforce, including medical students entering into residency; resident physicians entering into unsupervised practice; and practicing physicians who are near retirement, are not board certified, or do not actively practice clinical medicine but may wish to re-enter the physician workforce in the future.

Council on Medical Education Report 11, Impact of Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure on the Physician Workforce, recommends: 1) That our AMA reaffirm Policy H-275.924 (5), Maintenance of Certification (MOC), to reinforce that MOC requirements should not reduce the capacity of the overall physician workforce, and that it is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 2) That our AMA encourage the Federation of State Medical Boards to continue to work with state licensing boards to accept physician participation in maintenance of certification (MOC) and osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and that

MOC or OCC not be the only pathway to MOL for physicians. 3) That our AMA encourage the American Board of Medical Specialties to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA. 4) That our AMA reaffirm Policy D-300.984, Physician Re-entry, to reaffirm AMA's Guiding Principles on Re-entry and ensure that the AMA takes a leadership role to assure that its re-entry recommendations, including studying the workforce implications of a system that supports re-entry, are fully considered in any future initiatives on physician re-entry.

Your Reference Committee heard testimony largely in favor of this report. The Federation of State Medical Boards, for example, which is working with the American Board of Medical Specialties and National Board of Medical Examiners on MOC and MOL issues, provided testimony in support of the report. The Young Physicians Section offered testimony calling for annual follow-up reports on this topic for the next five years and for increased attention to the issue of re-entry. The Women Physicians Congress also expressed support for study of the issue of re-entry as part of future reports. Your Reference Committee feels that the Council on Medical Education and AMA staff have been (and continue to be) diligent in their work to research the availability of these data, and has done significant work to ensure smoother pathways for re-entry. The data on MOC's impact on the physician workforce are limited, in part, because MOC has not been in place long enough for a full assessment of this issue and because there is variability in the way MOC is being implemented across the specialty boards. Your Reference Committee expects that our AMA will continue to monitor this issue closely, encourage further investigation by key stakeholders, such as the American Board of Medical Specialties and Federation of State Medical Boards, and report back to the House of Delegates as appropriate. Therefore, your Reference Committee recommends that CME Report 11 be adopted.

(7) RESOLUTION 305 - MEDICAL STUDENT SUMMER RESEARCH
COMPENSATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 305 be adopted.

HOD ACTION: Resolution 305 adopted.

Resolution 305 asks that our AMA amend AMA Policy H-460.982 by insertion and deletion as follows: H-460.982 Availability of Professionals for Research - (1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. ~~The number of physicians~~ Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained into the 1990s. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for

grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred.

Your Reference Committee heard testimony in favor of this resolution, which entails a minor change to existing AMA policy intended to encourage financial compensation for medical students participating in medical research programs. This could help encourage greater student interest in careers in academia as well as those fields that are traditionally research-oriented. We therefore recommend adoption of this resolution.

(8) RESOLUTION 306 - PRELIMINARY YEAR PROGRAM PLACEMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 306 be adopted.

HOD ACTION: Resolution 306 adopted.

Resolution 306 asks that our AMA encourage the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

Your Reference Committee heard testimony in favor of this resolution. With a number of fields requiring a transitional or preliminary year in medicine or surgery prior to formal training, a subset of students interested in those disciplines must apply and match for two separate programs. This “double match” process has the potential to impose additional financial and logistical burdens on the student. Often, a student matches at a program in the desired field but matches for a transitional year at a separate institution—necessitating an additional relocation for the student. Many residency programs in the affected fields have started to integrate an intern year into their training; this resolution requests that our AMA support these efforts and encourage either integration or development of preliminary year training at nearby sites. A program director who provided testimony expressed opposition to the resolution as requiring a significant investment of time and money by programs and teaching hospitals. Nonetheless, your Reference Committee believes this resolution could ultimately benefit both the residency applicant as well as the residency program, helping to integrate the intern into the specialty program from day one and making the match process less stressful and financially burdensome, and thereby requests adoption of this resolution.

(9) RESOLUTION 311 - EARLY CAREER PHYSICIAN REPRESENTATION ON AMERICAN BOARD OF MEDICAL SPECIALTIES BOARDS

RECOMMENDATION: Mr. Speaker, your Reference Committee recommends that Resolution 311 be adopted.

HOD ACTION: Resolution 311 be adopted.

Resolution 311 asks that our AMA strive to place early career physicians onto American Board of Medical Specialties (ABMS) member specialty boards overseeing the Maintenance of Certification (MOC) process.

The AMA Council on Medical Education processes nominations for individuals seeking appointment to a number of ABMS member boards; it then forwards to our AMA Board of Trustees the names of those

individuals seen as the most qualified for the given position. The boards also often specify that nominees for open positions possess certain individual characteristics, such as specific administrative experience, or place restrictions on geographic locations of the nominees. AMA policy (H-275.931) calls for “diverse representation” on ABMS boards, which includes the need for consideration of multiple factors such as age, experience, and other demographic characteristics. Testimony was heard in favor of adoption. For example, the Council on Medical Education expressed its support as a means of ensuring a wide array of well-qualified applicants for nominations to key organizations. Accordingly, your Reference Committee urges adoption.

(10) RESOLUTION 315 - ADVANCEMENTS IN ADVOCACY AND MEDICAL CARE OF PERSONS WITH DEVELOPMENTAL DISABILITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 315 be adopted.

HOD ACTION: Resolution 315 adopted.

Resolution 315 asks that our AMA: 1) encourage clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; 2) encourage medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with developmental disabilities; 3) encourage medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, will improve quality in clinical care; 4) encourage the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; and 5) support a cooperative effort between physicians, Health and Human Services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

Your Reference Committee heard testimony in favor of this resolution and in opposition to reaffirmation of current AMA Policy H-90.975, which is limited to individuals with “profound” developmental disabilities. With the wide spectrum of impairments that persons with developmental disabilities can face, it is imperative that physicians know how to adequately address those in their care for this patient population. This resolution would help improve physicians’ and medical students’ understanding of the spectrum of developmental disabilities and help physicians advocate for appropriate and needed services for this patient population.

(11) RESOLUTION 331 - IMPROVING PATIENT SAFETY THROUGH COLLABORATION IN RESIDENT AND FELLOW EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 331 be adopted.

HOD ACTION: Resolution 331 adopted.

Resolution 331 asks our AMA to partner with stakeholder organizations including the Accreditation Council on Graduate Medical Education (ACGME) and American Osteopathic Association (AOA) to encourage partnership in the development and revision of residency and fellowship accreditation standards in order to better align the educational experience of allopathic and osteopathic residents and fellows with the overall goal of assuring patient safety.

Your Reference Committee heard testimony largely in favor of this resolution, which is important in that many osteopathic physicians are enrolled in allopathic residency programs. Accordingly, your Reference Committee calls for adoption as written.

(12) COUNCIL ON MEDICAL EDUCATION REPORT 2 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2002 HOUSE OF DELEGATES POLICIES AND DIRECTIVES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Recommendation in CME Report 2 be amended by insertion on page 1, lines 33-35, to read as follows:

The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of H-305.968, which should be rescinded; H-460.982 (4), which should be revised to delete "into the 1990s"; and H-310.927 (1) (8) (9) (10), which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendation in CME Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: CME Report 2 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 2, Council on Medical Education Sunset Review of 2002 House of Delegates Policies and Directives, is a review of House of Delegates' policies related to medical education last considered in 2002, and contains Council on Medical Education recommendations for retention or rescission of policies.

The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard limited but supportive testimony in favor of the recommendations of CME Report 2. In its work, your Reference Committee also noted a reference in Policy H-460.982 (4) to "into the 1990s"; we are requesting deletion of this phrase. In addition, it was noted that Policy H-305.968, Medicare Direct and Indirect Medical Education Costs, encompasses a "1996 Consensus Statement on Physician Workforce." Because this policy refers to, for example, "compelling evidence that the United States is on the verge of a serious oversupply of physicians," your Reference Committee recommends that this policy be rescinded. Live testimony was heard that H-310.927, parts (1) (8) (9) and (10) are still relevant and should be retained.

(13) COUNCIL ON MEDICAL EDUCATION REPORT 6 - INTERSTATE LICENSE PORTABILITY (RESOLUTION 313-A-10)

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in CME Report 6 be amended by insertion on page 4, lines 32-48, to read as follows:

That our AMA amend Policies H-160.940 and H-275.922 by insertion and deletion as follows:

H-160.940 Free Clinic Support: Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions.

H-275.922 Short-Term Physician Volunteer Opportunities Within the United States: Our AMA encourages the Federation of State Medical Boards to develop a ~~process~~ model policy for among the various state licensure boards to streamline and standardize the process by which that would make it possible for a physician who holds an unrestricted license in one state/district/territory may ~~to~~ participate in short term ~~(less than 90 day)~~ physician volunteerism in another U.S. state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: CME Report 6 adopted as amended and the remainder of the report filed.

At the 2010 Annual Meeting, our AMA House of Delegates referred Resolution 313, introduced by the Medical Student Section, which called on our AMA to study “a) the need for interstate license portability to allow physicians to volunteer in free clinics; b) the implications of current state policy in Tennessee, Oklahoma, and Arizona that allows for licensed physicians from other states to volunteer in their free clinics; and c) the effects on physician demographics, as well as the medical, financial, and legal implications, of interstate license portability for physician volunteers in free clinics.”

Council on Medical Education Report 6, Interstate License Portability, provides background information on free clinics and physician volunteers, details license barriers to physicians providing pro bono services in states in which they do not have a full license, identifies current systems of license portability, highlights relevant AMA policy, and presents recommendations. It recommends: 1) That our American Medical Association (AMA) reaffirm the following policies: H-160.953 “Free Clinics”; H-160.940 “Free Clinic Support”; H-275.978 “Medical Licensure”; H-480.969 “The Promotion of Quality Telemedicine”; D-275.994 “Facilitating Credentialing for State Licensure”; D-275.992 “Unified Medical License Application.” 2) That our AMA amend Policies H-160.940 and H-275.922 by insertion and deletion as follows: H-160.940 Free Clinic Support: Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other jurisdictions. H-275.922 Short-Term Physician Volunteer Opportunities Within the United States: Our AMA encourages the Federation of State Medical Boards to develop a ~~process~~ model policy for among the various state licensure boards to streamline and standardize the process by which that would make it possible for a physician who holds an unrestricted license in one state/district/territory may ~~to~~

participate in ~~short-term (less than 90-day)~~ physician volunteerism in another U.S. state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10)

Your Reference Committee heard limited but strong support for this report. With free clinics becoming more important to the overall health care delivery in many communities, particularly in underserved areas, our AMA should encourage efforts to lessen licensing barriers for potential physician volunteers. Allowing physicians to more easily cross state lines to serve in free clinics will increase the potential pool of volunteers in such clinics, especially those near state borders, and strengthen this vital link in our nation's health care safety net. In live testimony, a wording change was proposed to ensure that this report is limited to U.S. jurisdictions.

- (14) COUNCIL ON MEDICAL EDUCATION REPORT 10 - AN UPDATE ON MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, AND MAINTENANCE OF LICENSURE (RESOLUTIONS 331-A-11, 326-A-11, 316-A-11, AND 911-I-11)

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 in CME Report 10 be amended by insertion on page 15, lines 9-14, to read as follows:

That our AMA Reaffirm Policy H-275.924, Maintenance of Certification (MOC), to reaffirm that legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation to ensure that information released not violate the privacy or integrity of the patient/physician relationship.

Third Recommendation, Line 6 & 7:

Regarding Maintenance of Licensure, be amended by insertion and deletion to read as follows: Encourages the FSMB and state ~~licensing~~ medical and osteopathic boards to recognize that, if state medical or osteopathic boards move forward with the Maintenance of Licensure program, each state medical board should not revoke with regards to MOL, that active allopathic and osteopathic licenses should not be ~~revoked~~ on the basis of MOC or OCC requirements not being fulfilled ~~in a timely fashion because of the varying timeframes for certification and licensure.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 10 be adopted as amended and the remainder of the report be filed.

HOD ACTION: CME Report 10 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 10, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, responds to four resolutions and two AMA policies related to maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL).

Resolution 331-A-11, Legitimacy of the American Board of Medical Specialties (ABMS), introduced by the Connecticut Delegation, asked that our AMA study the validity, the methodology, cost, and effectiveness in documenting physician competence, of the re-credentialing system for board certification and report back to the House of Delegates (HOD) at the 2012 Annual Meeting.

Resolution 326-A-11, AMA Facilitation of MOL, introduced by the Young Physicians Section, asked that our AMA: 1) In coordination with state and specialty societies, study the feasibility and potential impact of an AMA member benefit program designed to: (1) act as a central repository for MOL, MOC, and/or OCC completion activities for an individual physician; and (2) facilitate an individual physician's efforts to complete required MOL, MOC, and/or OCC activities; and 2) Examine those state and specialty societies who have become actively engaged in facilitating the MOL implementation processes with a goal of identifying "best practices" regarding policy language, implementation programs, coordination activities, and other useful information that could be used by federation societies as they examine MOL implementation as it pertains to their society and report back to the HOD at the 2012 Annual Meeting.

Resolution 316-A-11, Continuing Medical Education (CME) for MOC, introduced by the New York Delegation, asked that our AMA: 1) Support the current CME accrediting system which provides high quality CME activities, thus ensuring continuous professional development as well as educational and practice improvement tools and resources; 2) Support the position of the Alliance for CME, which opposes the ABMS plan as stated because it would undermine the existing interdisciplinary approach to education and would also redirect important resources away from existing educational programs; and 3) Support the position of the Accreditation Council for Continuing Medical Education (ACCME), which opposes the creation of new systems that would impose unnecessary burdens upon ACCME-accredited providers, recognized accreditors, intrastate providers, and physician learners.

Resolution 911-I-11, Elimination of the Secured Examination Requirement for MOC, introduced by the Minnesota Delegation, asked that our AMA work with the ABMS to remove the requirement for a secure examination as part of their MOC program.

Policy D-275.961, Coordinated Efforts of Federation of State Medical Boards (FSMB), ABMS, and American Osteopathic Association (AOA) regarding MOL, directs our AMA to: 1) Encourage state medical boards to accept enrollment and participation in MOC and OCC as satisfactorily meeting the requirements of MOL, despite varying certification and licensing timeframes; 2) Continue to communicate with the FSMB, ABMS, and AOA the extent to which these organizations are working together (with regards to MOC and MOL) and report back to the HOD at the 2012 Annual Meeting; and 3) Encourage the FSMB and state medical boards to recognize, with regards to MOL, that active allopathic and osteopathic licenses should not be revoked on the basis of MOC or OCC requirements not being fulfilled in a timely fashion because of the varying time frames for certification and licensure.

Policy H-406.989, Work of the Task Force on the Release of Physician Data, calls for our AMA to: 1) Oppose the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; 2) Support the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care unless specifically approved by the physician; and 3) Report on how certification and licensure boards are currently using, or may potentially use, individual physician performance data (other than for individual physician performance improvement) that is reported for purposes of MOC, OCC, and MOL and report back to the HOD at the 2012 Annual Meeting.

CME Report 10 recommends that the following recommendations be adopted in lieu of Resolutions 331-A-11, 326-A-11, 316-A-11 and 911-I-11 and that the remainder of the report be filed: 1) That our American Medical Association (AMA) encourage the American Board of Medical Specialties and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. 2) That our AMA reaffirm Policy H-405.974, Specialty Recertification Examinations, to reinforce that AMA encourages the American Board of Medical Specialties and its member boards to

continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification. 3) That our AMA Policy D-275.961, Coordinated Efforts of Federation of State Medical Boards, American Board of Medical Specialties and American Osteopathic Association Regarding Maintenance of Licensure, be amended by insertion and deletion to read as follows: Encourages the FSMB and state ~~licensing~~ medical and osteopathic boards to recognize that, if state medical or osteopathic boards move forward with the Maintenance of Licensure program, each state medical board should not revoke ~~with regards to MOL, that active allopathic and osteopathic licenses should not be revoked~~ on the basis of MOC or OCC requirements not being fulfilled in a timely fashion because of the varying timeframes for certification and licensure. 4) That our AMA Reaffirm Policy H-275.924, Maintenance of Certification (MOC), to reaffirm that legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 5) That our AMA Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure, to reinforce that our AMA encourages members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 6) That our AMA Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure (MOL), that our AMA will (1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed; and (2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. 7) That the AMA Council on Medical Education continue to monitor the evolution of Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, continue its active engagement in the discussions regarding their implementation, and report back to the House of Delegates on these issues at the 2013 Annual Meeting.

Your Reference Committee heard extensive testimony on this complex and wide-ranging report. The Council on Medical Education submitted virtual testimony in favor of the report, while an individual asked for a number of changes in the report, calling for referral and further study of “the feasibility and potential impact of an AMA member benefit program designed to: (1) act as a central repository for MOL, MOC, and/or OCC completion activities for an individual physician; and (2) facilitate an individual physician’s efforts to complete required MOL, MOC, and/or OCC activities.” This individual’s testimony also called for further investigation into the extent to which the American Board of Medical Specialties, Federation of State Medical Boards, and American Osteopathic Association are working together on MOC, MOL and OCC, and for additional text in recommendation 5 (lines 16-20) to reflect our AMA as an organization to which Delegates can look for awareness and participation in issues related to self-regulation. Your Reference Committee appreciates the intent of these proposed changes, and, in fact, recommendation 7 (lines 33-37), already calls for close and continued monitoring of this rapidly changing issue and a follow up report at A-13. We also appreciate the intent of the suggested additional language in recommendation 5, but feel that the report itself serves as a tangible illustration of our AMA’s commitment to upholding the value of self-regulations and protecting and promoting the best interests of physicians and patients. In live testimony, an additional recommendation was proposed to state that our AMA “oppose release to the public of physician-specific information collected as part of Maintenance of Certification or Maintenance of Licensure.” Current AMA policy H-406.989 (6), however, already states that our AMA “opposes the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL.” There was also testimony calling for referral of this report, in that our AMA did not accomplish a study of a central repository for MOC/OCC/MOL, as requested in Resolution 326-A-11. Your Reference Committee believes that referral of Resolution 327 can be the mechanism to accomplish this. In addition, recommendation 7 states that the Council on Medical Education will continue to monitor this issue and report back at A-13, so your Reference Committee believes that referral is not needed. This should be considered a status “interim” report, and, as a work in progress, adequately covers the issue thus far, as noted in testimony from the Federation of State Medical Boards in support of adoption. Accordingly, your Reference Committee urges adoption of CME Report 10 as amended.

- (15) COUNCIL ON MEDICAL EDUCATION REPORT 12 - TRANSPARENCY IN THE NATIONAL RESIDENT MATCHING PROGRAM MATCH AGREEMENT (RESOLUTION 918-I-11, RESOLVE 2)

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that CME Report 12 be amended by deletion of Recommendation 4.

~~4. That our AMA encourage the NRMP to strive to meet the needs of its constituents, namely, the applicants and program directors. (Directive to Take Action)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 12 be adopted as amended and the remainder of the report be filed.

HOD ACTION: CME Report 12 adopted as amended and the remainder of the report filed.

Resolution 918-I-11, Transparency in the National Resident Matching Program Match Agreement, introduced by the Medical Student Section, asked that our AMA “1) Ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the Match and protecting the identities of both programs and participants; and 2) Advocate for the word ‘training’ in section 7.2.1 of the NRMP Match agreement be changed to ‘residency training’ and specifically state that NRMP cannot prevent an applicant from maintaining their education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs.” The first resolve was adopted at I-11, but the second resolve was referred for further study.

Council on Medical Education Report 12, Transparency in the National Resident Matching Program Match Agreement, recommends: 1) That our American Medical Association (AMA) reaffirm Policy D-310.974 (4), Policy Suggestions to Improve the National Resident Matching Program (NRMP). 2) That our AMA advocate that the words “residency training” in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, “The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report” and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs. 3) That our AMA work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred. 4) That our AMA encourage the NRMP to strive to meet the needs of its constituents, namely, the applicants and program directors.

Your Reference Committee heard limited but supportive testimony on this item. It is essential that the residency match process—a critical juncture in the career selection and education of our future physicians—ensures the highest levels of fairness and transparency. Potential violations of the National Resident Matching Program (NRMP) process are carefully evaluated by the NRMP, following its established procedures to ensure due process for its constituents. The NRMP has the authority to impose a wide range of consequences when a match agreement violation has been determined. Concern has been expressed that the range of these consequences not include prohibiting applicants from educational and training endeavors outside of graduate medical education—such a working in a research lab in a

clinical setting—since the NRMP’s scope is limited to residency positions. This would ensure that applicants could continue to pursue other related career options as appropriate to their interests. In addition, a small number of unintentional, preventable violations occur annually due to lack of clarity about the Match; the recommendations of this report should help to ameliorate this issue. Finally, the Reference Committee heard testimony that the fourth recommendation in the report was not needed. Accordingly, your Reference Committee urges that this report be adopted as amended.

(16) RESOLUTION 301 - INCREASED EMPHASIS ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN MEDICAL SCHOOL

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 301 be amended by insertion and deletion on page 1, lines 22-25, to read as follows:

RESOLVED, That our American Medical Association amend policy H-345.984 by insertion as follows:

Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses: (1) Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, ~~both when it occurs by itself and when it occurs either as the chief complaint or with another general medical condition~~; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings. (2) Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses. (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 301 changed to read as follows:

INCREASED EMPHASIS ON EDUCATION IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN MEDICAL SCHOOL

HOD ACTION: Resolution 301 adopted as amended with a change in title.

Resolution 301 asks that our AMA amend policy H-345.984 by insertion as follows: Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses: (1) Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, both when it occurs by itself and when it occurs with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings. (2) Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

Your Reference Committee heard limited but supportive testimony in favor of this resolution. For the sake of consistency, virtual testimony was submitted requesting insertion of “and other mental illnesses” at the end of line 25. In addition, your Reference Committee has proposed an editorial change to the end of (1)(a) to make the language parallel. The American Psychiatric Association recommended amending the title by adding “Education in,” which the Medical Student Section seconded. The Council on Medical Education testified in opposition to the resolution with the rationale that the amended language of the resolution would be an overly prescriptive mandate of curriculum. The point is well taken, but as the policy already specifies education on depression, and does not require but rather encourages education on this content, adding language to expand the topic to include other mental illnesses seems reasonable. Your Reference Committee therefore recommends adoption of this resolution as amended.

(17) RESOLUTION 302 - SECURING QUALITY EDUCATION SITES FOR US-ACCREDITED SCHOOLS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 302 be adopted:

HOD ACTION: Substitute Resolution 302 adopted.

RESOLVED, That our American Medical Association advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of United States LCME/COCA students in clinical rotations (New HOD Policy).

Resolution 302 asks that our AMA advocate for federal and/or state legislation or regulations opposing extraordinary payments by any medical school for access to clinical rotations.

This issue has grown in importance over the last few years as offshore medical schools have begun making payments to teaching hospitals (in certain states, such as New York) to ensure clerkship slots for their students. The Council on Medical Education reported on this issue in 2008 and 2009; both of these reports led to the adoption of AMA policy on this issue. Your Reference Committee heard mixed testimony on this resolution. Testimony by the Council on Medical Education called for substitute language, i.e., that our AMA “advocate for federal and/or state legislation for regulation opposing the displacement of United States LCME/COCA students in clinical rotations by any other medical school or clinical program.” The Medical Student Section, authors of the resolution, accepted the suggested alternate language. The language, while similar to AMA Directive D-295.320 (4), amplifies and strengthens the language adopted two years ago, reflecting the importance of this growing problem.

Testimony by a number of groups and individuals spoke to the increasing urgency of this problem related to medical student clinical placements. For example, some community hospitals or clinics affiliated with LCME- and COCA-accredited medical schools have either dropped their affiliations or have stopped accepting medical students for clinical placements from LCME- or COCA-accredited schools. Instead, they are accepting students from for-profit medical schools that are paying significant sums of money to the hospitals or clinics. The majority of testimony was in favor of this resolution. However, some spoke for referral because of the complexity of the issue, including concerns about restraint of trade and the desire not to restrict economic incentives that might be important to local hospitals needing additional revenue during difficult economic times. Your Reference Committee feels that AMA policy on this topic is clear and that the new language proposed by the resolution does not deviate from the intent of the original policy established after Council on Medical Education study two years ago. For this reason, your Reference Committee recommends adoption of the substitute resolution rather than referral for further study.

(18) RESOLUTION 309 - PRESERVING THE OPPORTUNITY TO
MOONLIGHT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 309 be amended by insertion and deletion on lines 30-34, to read as follows:

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) and graduate medical education programs to ~~discourage denying~~ allow resident and fellow physicians who are in good standing with their programs the opportunity for internal and external moonlighting that complies with current ACGME or AOA policy. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 309 be adopted as amended.

HOD ACTION: Resolution 309 adopted as amended.

Resolution 309 asks that our AMA work with the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) and graduate medical education programs to discourage denying resident and fellow physicians the opportunity for internal and external moonlighting that complies with current ACGME or AOA policy.

Your Reference Committee heard supportive testimony in favor of Resolution 309. With the enactment of resident/fellow duty hours over the last decade, and the continued increase in medical student debt loads, resident/fellow physicians potentially have understandable incentives to pursue moonlighting. This practice may also offer an added educational benefit to trainees. At the same time, residents and clinical fellows must ensure that moonlighting does not interfere with their ability to achieve the goals and objectives of their educational program, and they are responsible for ensuring that moonlighting and other outside activities do not result in fatigue that might affect patient care or learning. As long as these provisions are met, and as long as the moonlighting complies with current graduate medical education accreditation policy, this practice should not be discouraged. The Reference Committee heard testimony to revise the language on lines 30-34 to remove the double negative (“discourage denying”) and ensure that moonlighting is available only to those who are in good standing with their programs. Therefore, your Reference Committee recommends adoption of this resolution as amended.

(19) RESOLUTION 310 - AMERICAN BOARD OF MEDICAL SPECIALTIES
BOARD MEMBER ENROLLMENT IN MAINTENANCE OF
CERTIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 310 be amended by deletion on line 16, to read as follows:

RESOLVED, That our American Medical Association recommend to the American Board of Medical Specialties that all physician members of those boards governing the Maintenance of Certification (MOC) process be required to ~~fully~~ participate in the MOC process. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 310 be adopted as amended.

HOD ACTION: Resolution 310 adopted as amended.

Resolution 310 asks that our AMA recommend to the American Board of Medical Specialties that all physician members of those boards governing the Maintenance of Certification (MOC) process be required to fully participate in the MOC process.

Your Reference Committee heard testimony to support adoption of this resolution. A suggestion was offered to revise the language on line 16 by deletion of the word "fully." The rationale for this edit is that some certification board members only partially participate in MOC because they are test-writers for the objective testing part of the board exam. In general, however, as stated in a recent communication from staff of the American Board of Medical Specialties (ABMS), "All 24 ABMS Member Boards have policies in place that either require members of their individual boards to participate in their MOC programs or strongly recommend that members of their individual boards participate in their MOC programs. As of May 2012, all 24 ABMS Member Boards indicated that all members of their individual boards are participating in MOC." Your Reference Committee recommends adoption of this resolution as amended.

(20) RESOLUTION 314 - SUPPORTING TWO-INTERVAL GRADING
SYSTEMS FOR MEDICAL EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 314 be amended by insertion and deletion on lines 28-30, to read as follows:

RESOLVED, That our American Medical Association acknowledge the benefits of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum ~~the first two years of instruction~~ (New HOD Policy).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 314 be adopted as amended.

HOD ACTION: Resolution 314 adopted as amended.

Resolution 314 asks that our AMA acknowledge the benefits of a two-interval grading system in medical colleges and universities in the United States for the first two years of instruction.

Your Reference Committee heard testimony largely in support of adoption. The authors of the resolution cited research that a pass-fail system for the first two years of medical school could lower stress on students as well as reduce burnout and competitiveness. They also asserted that such a system does not affect subsequent performance on tests nor lower the rate of residency program placement. Testimony provided by the resolution's author also references the "considerable literature" suggesting that the majority of residency directors in every specialty do not value preclinical grades very highly. The Medical Student Section (MSS) spoke in favor of the resolution and cited a number of recent studies, including one by the NRMP, indicating that residency programs place little emphasis on non-clinical grades. The MSS offered additional language to the resolution, because not all schools have maintained the standard preclinical 2+2 curriculum structure. The Section on Medical Schools, and others, spoke about the changes that some schools have made from a two-interval grading system to "honors, high pass, etc," which then negates the utility of a pass/fail system. Others spoke of the growing trend to measure competency achievement of knowledge and skills, rather than any grading system, including pass/fail. The authors of the resolution indicated that they are not asking our AMA to advocate for or mandate a specific type of grading system. Rather, they ask only that our AMA "acknowledge the benefits" of such a system, versus advocating for its implementation. For these reasons, your Reference Committee recommends this resolution be adopted as amended.

(21) RESOLUTION 316 - ECONOMIC GROWTH AND DISTRIBUTION OF GME FUNDING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 316 be amended by insertion and deletion in the first resolve, on line 7, to read as follows:

RESOLVED, That our American Medical Association work with key organizations, such as the U.S. Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to support development of ~~author a~~ reports on the economic multiplier effect of each residency slot by geographic region and specialty (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 316 be amended by insertion and deletion in the second resolve, lines 11-12, to read as follows:

RESOLVED, That our AMA work with other key organizations, such as the U.S. Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to investigate the ~~association~~ impact of GME funding on each state and its impact on that state's health care workforce and health outcomes. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 316 be adopted as amended.

HOD ACTION: Resolution 316 adopted as amended.

Resolution 316 asks that our AMA: 1) author a report on the economic multiplier effect of each residency slot by geographic region and specialty, and 2) investigate the association of GME funding on each state and its impact on that state's health care workforce and health outcomes.

Your Reference Committee heard unanimous testimony in support of this item with its proposed amended language, which offers our AMA the opportunity to collaborate with other organizations that are currently working on the economic multiplier effect of resident physicians. Furthermore, your Reference Committee was concerned that without the suggested edits, the requested studies undertaken by our AMA alone would require an investment of time and resources so significant (as reflected in the high fiscal note) as to place an unreasonable burden on our AMA and divert its resources from other strategic priorities.

(22) RESOLUTION 319 - LESS COSTLY ALTERNATIVES TO MAINTENANCE OF SPECIALTY BOARD CERTIFICATION**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 319 be amended by insertion and deletion on lines 15-17, to read as follows:

RESOLVED, That our American Medical Association actively work to enforce existing policies ~~with regards to the activity and the efforts to~~ reduce ~~exorbitant~~ current costs and effort required for the maintenance of certification and to work to control future charges and expenses.
(Directive to take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 319 be adopted as amended.

HOD ACTION: Resolution 319 adopted as amended.

Resolution 319 asks that our AMA actively work to enforce existing policies with regards to the activity and the efforts to reduce exorbitant costs and effort required for the maintenance of certification.

Your Reference Committee heard extensive virtual and live testimony on this resolution reflecting physicians' concerns about the costs and complexity of MOC. For example, one individual submitted a multiple-page letter stating that "patients suffer when they lose valuable, experienced, practicing physicians due to a virtual monopoly exercised by [MOC programs]," and referenced one specialty board that is "using onerous but profitable procedures which may have distanced the organization from its original vision and mission." Testimony submitted by the Council on Medical Education noted that "the boards are acutely aware of the costs involved in all of their processes, since most of the board members themselves must maintain certification; and have heard from their constituents that efficiency and cost must be considered in the process." The resolution requests that our AMA actively work to enforce existing policies on this issue; your Reference Committee observes that our AMA continues this work, as seen by the examples of CME Reports 10-A-12 and 11-A-12. Because of the active, ongoing work by our AMA on these issues, and because our AMA has current policy on the concern expressed in this resolution, your Reference Committee recommends supporting Resolution 319 as amended.

(23) RESOLUTION 320 - INTRODUCING QUALITY AND PATIENT SAFETY
EDUCATION CURRICULUM IN UNDERGRADUATE MEDICAL
EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 320 be amended by insertion and deletion on lines 16-19, to read as follows:

RESOLVED, That our American Medical Association ~~urge~~ encourage the Liaison Committee on Medical Education to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medical students (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 320 be adopted as amended.

HOD ACTION: Resolution 320 adopted as amended.

Resolution 320 asks our AMA to urge the Liaison Committee on Medical Education (LCME) to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medical students.

Your Reference Committee heard mixed testimony on this resolution. In its testimony expressing opposition to Resolution 320, the Council on Medical Education noted our AMA's long-standing opposition to mandating curriculum: "The LCME . . . limits the mandate of specific curricular requirements This affords the greatest degree of flexibility in how the teaching plan is conducted in each setting while meeting the requirements to produce trainees who have the ability to provide adequate care to patients in the future. . . . The Council therefore believes that while the intent of the resolution is commendable, the implementation of an additional curricular mandate is not necessary." In addition, attention to quality and patient safety is already part of the review of medical schools through the LCME. Accreditation standard ED-10, for example, includes the expectation that patient safety and health care quality improvement are included in the curriculum. Medical schools are asked to supply to the LCME information on how these subjects are included in the curriculum. Others testified to the great importance of this topic in current medical student education and felt that the intent of the resolution fits well with the new AMA strategic focus area intended to accelerate change in medical education. Further, testimony indicated that this curricular topic was not specifically called for in the LCME standards, but rather included within a list of behavioral and social sciences curricula, thereby reducing the importance of the subject. Your Reference Committee therefore recommends supporting the intent of Resolution 320, while respecting the testimony of Council and others not to mandate curriculum, by recommending the adoption of the amended language to encourage the inclusion of this curriculum content in medical student education.

(24) RESOLUTION 321 - MEDICAL SCHOOL STUDENT LOANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 321 be amended by insertion and deletion on lines 1-5, to read as follows:

RESOLVED, That our American Medical Association encourage ~~support~~ the National Health Services Corps to have repayment policies that are

~~consistent with other federal loan forgiveness programs, and similar repayment programs in developing initiatives which would include Direct Parent Student Loans or PLUS loans as an eligible loan when the applying physician is the sole or primary borrower; thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas in primary medicine.~~ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 321 be adopted as amended.

HOD ACTION: Resolution 321 adopted as amended.

Resolution 321 asks our AMA to support the National Health Services Corps (NHSC) and similar repayment programs in developing initiatives which would include Direct Parent Student Loans or PLUS loans as an eligible loan when the applying physician is the sole or primary borrower; thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas in primary medicine.

Your Reference Committee heard testimony largely in support of this resolution. Currently, the National Health Service Corps recognizes GradPLUS loans for loan forgiveness but not the Parent Direct PLUS loan. The authors of the resolution called for ensuring that the loan forgiveness policies of the National Health Service Corps are consistent with those of other federal loan programs. Because there was some confusion as to the particulars of NHSC loan policies, your Reference Committee believes the proposed revisions offer our AMA flexibility in pursuing its ongoing work of ensuring that physicians are provided opportunities to take advantage of this and other federal loan forgiveness programs.

(25) RESOLUTION 323 - ARBITRARY PREVENTION OF J-1 VISA IMGs FROM REENTRY INTO THE US

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 323 be amended by insertion and deletion on lines 1-2, to read as follows:

RESOLVED, That our AMA, in collaboration with other stakeholders, ~~work to insure that IMGs are permitted~~ advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care. (Directive to take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 323 be adopted as amended.

HOD ACTION: Resolution 323 adopted as amended.

Resolution 323 asks our AMA to: 1) study, in collaboration with the Educational Commission on Foreign Medical Graduates (ECFMG) and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training; and 2) in collaboration with other stakeholders, work to insure that IMGs are permitted unfettered travel for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Your Reference Committee heard testimony on this resolution in favor of the revised language. Testimony from the Council on Medical Education noted that it may be difficult to accurately measure the impact of J-1 Visa reentry denials on patient care. The frequency of such denials and the impact on residency training would be much easier to measure and is an important issue that needs to be addressed. The Council's proposed language change in Resolve 2 recognizes that, while our AMA can advocate with U.S. consulates and embassies on this issue, it would be difficult to ensure the unfettered travel of residents and fellows seeking reentry to the U.S. It is also important to highlight that this resolution applies to physicians who have already been in the U.S. on a J-1 visa, not those who are coming here for the first time. Your Reference Committee therefore recommends adoption as amended.

- (26) RESOLUTION 317 - PHYSICIAN WORKFORCE SHORTAGES
RESOLUTION 329 - GOING FORWARD WITH
REFORMING GME FINANCING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 317 and Resolution 329 be referred.

HOD ACTION: Resolution 317 and Resolution 329 referred.

Resolution 317 asks that our AMA work diligently with the Centers for Medicare & Medicaid Services (CMS) and the U.S. Congress to create a supplemental private funding opportunity in addition to current funding sources to help develop additional residency training positions with private donations to cope with the critical shortage of primary care physicians in our country.

Resolution 329 asks our AMA to: 1) work with all available internal data and other available sources to craft a new national model for sustainable funding of graduate medical education (GME) programs, which includes not only the Centers for Medicare & Medicaid Services (CMS) funding, but also private funding sources as well and 2) urgently work to implement via legislation and other means this new model for funding GME programs in the United States.

Your Reference Committee heard mixed testimony on Resolution 317 and Resolution 329. For example, for Resolution 317, it was noted that the phrase "supplemental private funding opportunity" could be problematic in that "it is open for significant latitude in interpretation and could include such entities as pharmaceutical companies." In addition, testimony was submitted in opposition to the resolution in that CMS and the U.S. Congress cannot create a "supplemental private funding opportunity." A strategy that would obtain similar results would be to support state initiatives for all-payer funding. AMA policy supports an all-payer system of graduate medical education funding, with funding from federal, state, and private/commercial payers alike.

Your Reference Committee heard similar testimony on Resolution 329, which requests that our AMA take action on a closely related GME topic. While all acknowledged the critical importance of increasing GME training slots, many expressed various opinions on our AMA's role in offering one specific solution to this important issue. The Council on Medical Education indicated that our AMA has ample policy in this area and asked that current AMA policy be reaffirmed in lieu of this resolution. Others spoke in opposition to the resolution and asked that it be combined with Resolution 317. Because of the complexities of these issues, the need for increased GME slots to support the U.S. physician workforce and the timeliness of these concerns, your Reference Committee supports the intent of Resolution 317 and Resolution 329 but recommends they be referred for further study.

(27) RESOLUTION 327 - RETENTION AND AVAILABILITY OF
CONTINUING MEDICAL EDUCATION PARTICIPATION RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 327 be referred.

HOD ACTION: Resolution 327 referred.

Resolution 327 asks our AMA to: 1) work with the Accreditation Council for Continuing Medical Education (ACCME) and continuing medical education (CME) providers that it accredits to ensure that each CME provider will make available to a central data repository a transcript of all CME credits earned by a physician from the CME provider, including date, credits earned, and program title; and 2) work with the ACCME to make physician CME transcripts available to the physician online and in real time in a format suitable for submission to licensing and other organizations without cost to the physician.

Your Reference Committee heard largely favorable yet mixed testimony that articulated the need for a business product proposal to study the feasibility of this item. It was noted, for example, that a central data repository service would potentially be very useful for physicians and could expand the member value of our AMA by tracking continuing medical education as well as maintenance of certification and osteopathic continuous certification as noted in CME Report 10-A-12. Speaking against adoption, the Council on Medical Education noted that the cost of such a service would almost invariably be borne by physicians, despite the statement to the contrary in the second resolve. In addition, Council testimony noted that state or specialty societies, hospitals, and Area Health Education Centers (AHECs) already provide similar services, and our AMA could be duplicating these services. State societies may be better able to reach more physicians to serve this need. The resolution asks that our AMA work with the Accreditation Council for Continuing Medical Education on the "central data repository" but is not specific about the mechanism for such a collaboration. Your Reference Committee believes that this proposal would benefit from an additional study to clarify the mechanisms and costs of implementing a service as intended in the resolution and therefore recommends referral for report.

(28) RESOLUTION 328 - THE CHANGING TRAINING ENVIRONMENT:
ACCESS TO PROCEDURAL TRAINING FOR RESIDENTS AND
FELLOWS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 328 be referred.

HOD ACTION: Resolution 328 referred.

Resolution 328 asks our AMA to: 1) study the trends in numbers of residency training sites that also employ mid-level providers and/or concurrently train students of these midlevel programs; 2) more clearly define a physician-in-training's role in the hospital and specifically make it a high educational priority for trainees to receive the needed exposure to procedures required for them to master competency in their specialty and that these exposures are not delegated to midlevel providers and mid-level provider trainees; and 3) study the financial impact for institutional training sites of hiring more mid-level providers versus investing in a physician training program.

Your Reference Committee heard mixed testimony on this item, with strong support for referral. Testimony in opposition to the resolution was submitted by the Council on Medical Education, noting that Resolve 1 and Resolve 3 call for studies that would be expensive to perform, with results that may not ultimately be helpful or insightful. In the case of Resolve 3, current research already shows that substitution of resident/fellow labor by mid-level providers is more expensive. Further, the AMA studies

proposed in Resolve 1 and Resolve 3 are not within the scope of current AMA staff or data resources. A fiscal analysis was done to determine what additional resources would be needed to accomplish the requested study; the resulting fiscal note is high, and there is no guarantee that the question posed would be answered. Regarding Resolve 2, it is apparent that quality of care concerns will arise if resident physicians are not obtaining adequate instruction/experience in various clinical procedures. For this reason, the Accreditation Council for Graduate Medical Education (ACGME) already has requirements in place that prevent residents' progression through training if they are not receiving adequate clinical experiences. The AMA's involvement in defining the role of physicians-in-training is accomplished through AMA representation on the ACGME Board of Directors, as reflected in current AMA policy. Finally, it must be acknowledged that it has been beneficial in some aspects of resident training to have mid-level providers available to perform non-educational clinical work, and it would be undesirable to return to the times when residents were asked to perform such duties at the expense of their educational training opportunities.

In summary, while it is possible that mid-level providers may have an adverse effect on or deprive medical students and residents of needed training opportunities, their presence has also enhanced the education of students and residents and contributed to a better understanding of team-based care and collaboration. Due to the complexity of these issues, the stated fiscal note, the need for a team-based environment, and local institutional practices, your Reference Committee recommends that Resolution 328 be referred.

(29) RESOLUTION 307 - INCREASING ORGAN DONATION DISCUSSIONS THROUGH MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 307 not be adopted.

HOD ACTION: Resolution 307 not adopted.

Resolution 307, introduced by the Medical Student Section, asks that our AMA: 1) compile current materials into a comprehensive resource available for the development of a Continuing Medical Education course educating physicians on how to conduct organ donation discussions with patients; and 2) AMA support the development of billing codes for physician-patient organ donation discussions.

Your Reference Committee heard testimony against adoption of Resolution 307. All speakers acknowledged the importance of this topic and appreciated the intent of this resolution from the MSS. However, testimony and supporting data introduced by several surgical societies indicated that the ideal approach to encouraging organ transplant is through the expertise of the transplant care team, including the use of transplant coordinators. Additionally, the approach in discussing this topic differs depending on whether one is working in an office-based environment or talking about organ transplantation from deceased (versus live) donors. Also, the Council on Medical Education called for deletion of the Second Resolve: Billing codes already exist for discussion of advance directives, and our AMA currently has several policies supporting the incorporation of organ donation discussion into the advance directive (H270.963, H370.977). Accordingly, your Reference Committee recommends that Resolution 307 not be adopted.

(30) RESOLUTION 330 - PROPOSAL FOR A RETROSPECTIVE WORKFORCE STUDY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 330 not be adopted.

HOD ACTION: Resolution 330 not adopted.

Resolution 330, introduced by the Organized Medical Staff Section, asks our AMA to: 1) collaborate with governmental entities and other appropriate organizations to complete a 30-year, retrospective analysis of how the workforce in health care has readjusted to absorb the influx of workers who are not directly or indirectly involved in patient care. This analysis should pay particular attention to the numbers/proportion of those in the health care workforce who take direct care of patients now, as compared to past decades, and those who support that effort, even indirectly and 2) report back at the 2013 Annual Meeting. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this resolution. The Council on Medical Education recommended against adoption because of the complexity of the issue and the lack of identified rationale for the usefulness of such a study. Other organizations also indicated a lack of support or urged referral. Concerns were expressed that the method suggested by the study—a 30-year retrospective analysis—may not be the best way to identify issues, and questions were raised about the purpose of the study, indicating that this information is already available elsewhere and would be repetitive. Because the rationale for this proposed resolution has not been developed and the methodology has not been justified, nor is it clear that this request covers new questions, your Reference Committee recommends against adoption of Resolution 330.

(31) RESOLUTION 303 - INVESTIGATING ADVERSE HEALTH OUTCOMES
RELATING TO CHRONIC GRADUATE MEDICAL EDUCATION
FUNDING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, be reaffirmed in lieu of Resolution 303.

HOD ACTION: HOD Policy D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, reaffirmed in lieu of Resolution 303.

Resolution 303 asks that our AMA encourage appropriate stakeholder organizations to study and quantify the public health impacts of cuts to graduate medical education funding sources, including, but not limited to, the effects on the physician shortage, spending on public health initiatives, and availability and quality of care.

Your Reference Committee heard testimony largely in favor of this resolution, which could help raise awareness among patients of the potential impact of GME funding cuts. During the testimony, the resolution's author, the Council and the Medical Student Section all indicated their support for reaffirmation of current AMA policy on this topic. It should also be noted that other organizations are carrying out this work—in particular, the Association of American Medical Colleges, through its “Careful what you cut” advocacy campaign. The AMA has extensive and detailed policy that calls for adequate GME funding and affirms the role of GME as a resource contributing to equity in availability of health care for the public. Your Reference Committee therefore recommends supporting the intent of Resolution 303 through reaffirmation of existing AMA policy.

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and

others). 2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions. 3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997). 4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation. 5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty. 6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.). 7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care. 8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME. 9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality. 10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME. 11. Our AMA: (A) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (B) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (C) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11)

(32) RESOLUTION 312 - THE DEFICIENCY IN MEDICAL EDUCATION
RELATING TO AUTOPSY

RECOMMENDATION: Mr. Speaker, your Reference Committee recommends that Policy H-85.993, Autopsies, be reaffirmed in lieu of Resolution 312.

HOD ACTION: HOD Policy H-85.993, Autopsies, reaffirmed in lieu of Resolution 312.

Resolution 312 asks that our AMA: 1) continue to work with all relevant organizations to advocate for participation in an autopsy during medical school or residency training; 2) continue to work with all relevant organizations to overcome legislative and other barriers to improve autopsy rates; and 3) work with all relevant parties to develop a model curriculum or teaching module on discussion of autopsy, obtaining consent, and autopsy results as part of a patient care specialty.

The decline in autopsies has been noted in both peer-reviewed literature and the general media. Concern over legal repercussions along with preferences and religious beliefs of the decedent's family may play a role in the decline as well. Your Reference Committee heard limited but supportive testimony on this resolution, with the Council on Medical Education and an individual expressing support for reaffirmation of current AMA policy. Colleagues from the field of pathology also recommended adoption of the resolution. As the intent behind this resolution is captured in current AMA Policy H-85.993 and seven other related

AMA policies on autopsy and medical education, your Reference Committee recommends supporting the intent of Resolution 312 through reaffirmation of this policy.

H-85.993 Autopsies

The AMA (1) reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program; and (2) urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance. (Sub. Res. 11, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)

(33) RESOLUTION 313 - COSTS OF ASSESSING CLINICAL COMPETENCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-300.982, Maintaining Competence of Health Professionals; H-275.936, Mechanisms to Measure Physician Competency; H-405.974, Specialty Recertification Examinations; H-275.923, Maintenance of Certification / Maintenance of Licensure; H-275.924, Maintenance of Certification; H-275.956, Demonstration of Clinical Competence; D-275.971, American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements; and D-270.989, Improvements to the Maintenance of Certification Process, be reaffirmed in lieu of Resolution 313.

HOD ACTION: HOD Policies H-300.982, Maintaining Competence of Health Professionals; H-275.936, Mechanisms to Measure Physician Competency; H-405.974, Specialty Recertification Examinations; H-275.923, Maintenance of Certification / Maintenance of Licensure; H-275.924, Maintenance of Certification; H-275.956, Demonstration of Clinical Competence; D-275.971, American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements; and D-270.989, Improvements to the Maintenance of Certification Process, reaffirmed in lieu of Resolution 313.

Resolution 313 asks that our AMA: 1) support the concept that any method used to determine clinical competence be supported by evidence of effectiveness in determining clinical competence; 2) work in the federation of medicine to promote that all specialties only use tests of clinical competence that have been proven effective or set up pilot projects to test for effectiveness; 3) work to have all state licensing boards agree to only use methods to test clinical competence that have been proven effective; 4) observe methods used by specialties to determine clinical competence to be sure they are truly testing clinical competence and not tools being used in turf battles; and 5) keep our legislators informed on the effect these maintenance of certification and maintenance of licensure efforts might have on medical workforce by aggravating the shortages of physicians in critical specialties through making it more difficult and expensive to continue to practice medicine.

Competence is assessed in a number of ways and can vary from specialty to specialty. Although specialty board certification is not required to practice medicine, board certification provides assurance that a physician has met specific criteria. It is important to note that our AMA supports the board certification process and its intended outcomes, but is not responsible for regulating the process. Nonetheless, our AMA is actively involved in this issue, and has extensive policy on maintenance of certification (MOC) as well as policy to support the principles of maintenance of licensure (MOL). The AMA advocates for balancing these requirements with a sensitivity to physicians' valuable time and resources, ensuring physician input into the ongoing development of MOC and MOL, and making both MOC and MOL processes as efficient, effective, and evidence-based as possible. AMA policy states that

MOC requirements should not reduce the capacity of the overall physician workforce. Policy also states that it is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. Your Reference Committee heard testimony from the Council on Medical Education that it is actively monitoring new developments in MOC and MOL, as evidenced by its annual reports on this topic to our AMA HOD. Accordingly, your Reference Committee recommends supporting the intent of Resolution 313 through reaffirmation of existing AMA policy.

H-300.982 Maintaining Competence of Health Professionals

(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such standards should be reviewed and revised periodically. (4) When reliable and cost-effective means of assessing continuing competence are developed, they should be required for continued practice. (5) Patient relations and ethics are appropriate subjects for continuing education; educational providers should increase the offering in these fields. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 17, A-04)

H-275.936 Mechanisms to Measure Physician Competency

Our AMA (1) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (2) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-405.974 Specialty Recertification Examinations

Our AMA (1) encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification; and (2) believes that the holder of a certificate without time limits should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.923 Maintenance of Certification / Maintenance of Licensure

Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. 2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. 5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. 6. Continue to participate in the NAPC forums. 7. Encourage members of our

House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 8. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the U.S., including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. 10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11)

H-275.924 Maintenance of Certification

AMA Principles on Maintenance of Certification (MOC): 1.Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician's Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09)

H-275.956 Demonstration of Clinical Competence

It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians. (CME Rep. E, A-90; Reaffirmed: CME Rep. 5, A-99; Modified: Sub. Res. 821, I-02; Modified: CME Rep. 1, I-03; Reaffirmed: CME Rep. 16, A-09)

D-275.971 American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements

Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

D-270.989 Improvements to the Maintenance of Certification Process

By September 15, 2008, our AMA Board of Trustees will write a letter to the American Board of Medical Specialties (ABMS) asking that it work with its 24 member boards to: a. coordinate with each other, the ABMS, specialty societies and the AMA to ensure that the demands of Maintenance of Certification (MOC) are reasonable; b. educate physicians and increase their understanding of the MOC process and its requirements; c. solicit physician input and feedback regarding MOC implementation; d. make transparent all recertification-related costs; e. work to minimize the disruption of physician practice due to MOC requirements; and f. ensure that the number of MOC-related testing dates and the locations of testing sites are ample enough to minimize the burden on physician practices and their time away from clinical care. (Res. 323, A-08; Reaffirmed: CME Rep. 16, A-09)

(34) RESOLUTION 324 - GRADUATE MEDICAL EDUCATION**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policies D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, and H-310.917, Securing Funding for Graduate Medical Education, be reaffirmed in lieu of Resolution 324.

HOD ACTION: HOD Policies D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, and H-310.917, Securing Funding for Graduate Medical Education, reaffirmed in lieu of Resolution 324.

Resolution 324 asks our AMA to: 1) lobby Congress for funding for more residency training positions in the U.S.; and 2) advocate for more residency training positions in the U.S. to accommodate the need for more physicians in the workforce to address the physician shortage.

Your Reference Committee heard limited testimony in support of this resolution. There was testimony that called for support of the recommendations in the 20th report of the Council on Graduate Medical Education, but your Reference Committee believes that current AMA policy is adequate. Further, our AMA is actively working at federal and state levels to advocate for expansion of GME training opportunities in all undersupplied specialties, as evidenced by legislative updates that have been provided at AMA Annual and Interim meetings and the National Advocacy Caucus. Because our AMA already has significant policy (including D-305.967 and H-310.917) on this issue, your Reference

Committee recommends supporting the intent of Resolution 324 through reaffirmation of existing AMA policy.

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others). 2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions. 3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997). 4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation. 5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty. 6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.). 7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care. 8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME. 9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality. 10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME. 11. Our AMA: (A) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (B) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of our AMA in its national political agenda; and (C) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11)

H-310.917 Securing Funding for Graduate Medical Education

Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation. (CME Rep. 3, I-09; Modified: CME Rep. 15, A-10)

(35) RESOLUTION 325 - CURRICULA FOR PAIN EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-295.982, Model Pain Management Program for Medical School Curricula, be reaffirmed in lieu of Resolution 325.

HOD ACTION: Resolution 325 referred.

Resolution 325 asks that our AMA work with all agencies, government bodies and other stakeholder organizations associated with developing, coordinating, and maintaining curricula for pain education, in cooperation with relevant medical specialty societies, to provide education about pain neurobiology, evaluation, and treatment to all medical students.

Your Reference Committee heard testimony, from the Council on Medical Education, in favor of reaffirmation of current AMA policy. The AMA does not support mandating medical education curricula, although this could be offered as elective curriculum content. In addition, in recent years our AMA has offered an in-depth pain management education program which has enrolled almost 110,000 participants (including 20,000 non-physicians); a revised version is planned for release later this year. Testimony from the author and the American Academy of Pain Medicine argued for new policy, indicating that current AMA policy on this topic is more than 10 years old and the new resolution offered stronger language. However, your Reference Committee notes that AMA policy on this topic was reaffirmed with an extensive Council report (CME Report 2) during A-11. For these reasons, your Reference Committee recommends supporting the intent of Resolution 325 through reaffirmation of existing AMA policy.

D-295.982 Model Pain Management Program For Medical School Curricula
Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs.
(Res. 308, A-01; Reaffirmed: CME Rep. 2, A-11)

Reference Committee D (Public Health)

- (1) BOARD OF TRUSTEES REPORT 5 - AMA ACTIVITIES AS A PARTNER OF THE MILLION HEARTS INITIATIVE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 5 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 5 adopted and the remainder of the report filed.

The Million Hearts initiative is a national campaign aiming to prevent one million heart attacks and strokes over the next five years. At the 2011 Interim Meeting, the AMA House of Delegates adopted AMA Policy D-425.993 which asked that the American Medical Association Board of Trustees report back to the HOD at the 2012 Annual Meeting on the actions the AMA has taken as a partner in the Million Hearts Initiative to ensure its success.

As this report fulfills the request of the House of Delegates, the Board of Trustees recommends that the AMA Policy D-425.993 be rescinded and the remainder of this report be filed.

Your Reference Committee received limited but favorable virtual and live testimony. The testimony concurred with the recommendations and encouraged the AMA to “embed” this initiative into the strategic initiative to improve health outcomes. The report recognizes the importance of heart health and the value of the Million Hearts initiative, which is reflected in the breadth of our AMA activities on this issue. Your Reference Committee agreed that the AMA should continue to collaborate on the Initiative, remain in close communication with the different federal agencies leading the effort, and continue to explore ways that we might engage in promoting and accomplishing the goals of this effort.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - SAFETY OF BOTTLED WATER

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 3 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 3 adopted and the remainder of the report filed.

Resolution 420-A-11 “Public Health Concerns with Safety of Bottled Water,” was referred to the Board of Trustees and asked (1) the AMA to publicly call for immediate action on the part of the bottled water industry to bring up the level of fluoride in their water to the same level as required in the community where bottles are filled and that information be placed on the label along with the original source of water in plain English, and (2) for the Council on Science and Public Health to study the various public health concerns that arise from bottled water and recommendations to make bottled water safer and consumers better informed with report back at A-12.

This report summarizes existing data on the safety of bottled water and the public health impact, to include fluoride intake, on water consumption patterns. It notes that current AMA Policy D-440.999 supports federal regulation and appropriate labeling of the chemical content of commercially bottled water, encourages promotion of fluoridated bottled water to consumers. Also, AMA Policy H-440.972 supports a comprehensive program of fluoridation of all public water supplies that are fluoride-deficient

based on current standards. The Council on Science and Public Health recommends that the following statement be adopted in lieu of Resolution 420-A-11:

That D-440.999 [Chemical Analysis Report of Public and Commercial Water] be amended by insertion and deletion to read as follows:

Our AMA: (1) requests the appropriate federal agency to require analysis and appropriate labeling of the chemical content, including fluoride, of commercially bottled water, as well as of the water supplies of cities or towns; (2) ~~will work with the American Dental Association to promote the availability of fluoridated, commercially bottled water to consumers.~~ urges the FDA to require that annual water quality reports from bottled water manufacturers be publicly accessible in a readily available format; and (3) urges the FDA to evaluate bottled water for changes in quality after typical storage conditions. (Modify Current HOD Policy)

Your Reference Committee received virtual testimony on this report from the Council on Science and Public Health, indicating the lack of compelling evidence to question the overall safety of bottled water in the United States, as well as the need for more transparent, accessible reporting of bottled water quality reports. Receiving limited testimony in the live Reference Committee, FDA did submit editorial changes. Your Reference Committee concurred with the Council's recommendation to amend current AMA policy on this topic given that current AMA policy supports federal regulation and appropriate labeling of the chemical content of commercially bottled water, as well as efforts to promote the availability of fluoridated bottled water to consumers.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 - TAXES
ON BEVERAGES WITH ADDED SWEETENERS

RESOLUTION 407 - ARTIFICIAL BEVERAGES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 5 be adopted in lieu of Resolution 407 and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 5 adopted in lieu of Resolution 407 and the remainder of the report filed.

The purpose of this report is to determine if the scientific literature supports the assertion that limiting consumption of beverages with added sweeteners (sugar-sweetened beverages [SSBs]) is likely to improve health outcomes; and, if so, whether taxation of SSBs would be an effective public health strategy to help reduce consumption. While SSB taxes alone are unlikely to significantly impact the prevalence of obesity and other adverse outcomes, the Council recognizes that a wide array of efforts are necessary to reduce SSB consumption and improve public health; SSB taxes are one means by which local, state, or federal governments may choose to finance these efforts. The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 417-A-11 and the remainder of this report be filed:

1. Our American Medical Association (AMA) recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic. (New HOD Policy)

2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes. (New HOD Policy)
3. That our AMA advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents. (Directive to Take Action)

Resolution 407 asks that our American Medical Association convene a multidisciplinary, impartial advisory panel to study, recommend, propose and support development of innovative research studies, including randomized, controlled trials and other mechanisms by which the effects of artificial beverage consumption or lack thereof on the development of obesity and atherosclerotic cardiovascular disease can be defined and used to effect appropriate public policy.

Regarding CSAPH 5, your Reference Committee received diverse virtual testimony, then supportive live testimony. The testimony indicated that the rise in obesity is multifactorial to include lack of exercise, age, genetics, and consumption of high-calorie foods and beverages. Also, it was noted that in isolation, a tax on SSBs imposed on a population is unlikely to stop or reverse the obesity trend; on the other hand, reducing intake of SSBs is a simple way to reduce intake of added sweeteners without compromising the nutrient adequacy of the overall diet. Given the strong and consistent associations of SSBs with body weight and several cardiometabolic conditions, limiting consumption of SSBs is likely to improve health outcomes. Testimony also suggested that taxation of sugar should be considered, as well as removal of sugar/corn subsidies to help reduce the burden of diseases related to obesity and diabetes. Concern was raised that the second resolve may be problematic for municipalities since it prescribes how to spend tax revenues derived from the taxation of SSBs. Your Reference Committee continued a spirited discussion acknowledging that SSB taxes are one means by which local, state, or federal governments may choose to address this issue, however a wide array of efforts are necessary to reduce SSB consumption and impact obesity rates.

Regarding Resolution 407, your Reference Committee received limited virtual and live testimony on this resolution which favored referral. Your Reference Committee was concerned about the large fiscal note attached to this resolution given the proposed advisory panel and its duties, and questioned if this activity goes beyond the scope of the AMA. Because the Council on Science and Public Health report 5 [Taxes on Beverages with Added Sweeteners (A-12)] “advocates for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents,” your Reference Committee recognized the importance of the study of artificial beverages and its impact on health and they concurred that current AMA activities, reports, and policies are addressing this issue. AMA Policy D-150.981 encourages “independent research on the health effects of high fructose corn syrup and other sweeteners”. Therefore your Reference Committee recommends that the recommendations in CSAPH 5 be adopted in lieu of Resolution 407.

- (4) RESOLUTION 402 - REDUCING SUICIDE RISK AMONG LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUESTIONING YOUTH THROUGH COLLABORATION WITH ALLIED ORGANIZATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 402 be adopted.

HOD ACTION: Resolution 402 adopted.

Resolution 402 asks that our American Medical Association partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Your Reference Committee received limited testimony on this resolution and agreed that LGBTQ youth suicide is a serious public health issue and that there is a need to focus on the LGBTQ community given the higher rates of suicide as compared to the rest of the youth population. Your Reference Committee also recognized the importance of using inclusive language in order to recognize lesbian, gay, bisexual, transgender, and questioning individuals.

(5) RESOLUTION 423 - LIFESTYLE MEDICINE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 423 be adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 423 be changed to read as follows:

HEALTHY LIFESTYLES

HOD ACTION: Resolution 423 adopted with a change in title.

Resolution 423 asks that our American Medical Association (1) recognize the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010, (2) urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine, and (3) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.

Your Reference Committee received limited virtual and live testimony. The preliminary report stimulated a discussion about the title. Your Reference Committee expressed concern about the use of the word "medicine" in the title and therefore offered a change in title. Testimony was supportive of the resolution and clarified the rationale for the original title which was to reflect the need for competencies for physicians to use to guide education and training in medicine. Your Reference Committee is supportive of the overall intent to assist physicians in addressing lifestyle factors in order to improve chronic disease and treatment efforts.

(6) RESOLUTION 417 - TAX INCENTIVES FOR FILMS DEPICTING TOBACCO

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 417 be adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 417 be changed to read as follows:

TAX INCENTIVES AND FILMS DEPICTING TOBACCO

HOD ACTION: Resolution 417 adopted with a change in title.

This resolution asks that our American Medical Association urge that no tax incentives be given for any motion picture production that depicts any tobacco product or non-pharmaceutical nicotine delivery device or its use, associated paraphernalia, related trademarks or promotional material, unless the film depicts the tobacco use of historical persons or unambiguously portrays the dire health consequences of tobacco use.

Your Reference Committee received limited but favorable testimony on this resolution, and agrees that there is great merit to limiting the state and federal tax subsidies available for movie productions that depict tobacco use. As the resolution highlights, the precedent of limiting subsidies for movies depicting particular scenarios that may discriminate, offend, and/or portray unhealthy actions has already been set. It was noted that our AMA continues to be a leading voice in tobacco prevention and cessation efforts, and serves as a lead agency in Smoke Free Movies, an on-going national effort to eliminate the influence of smoking in movies on youth smoking behaviors. This resolution extends that commitment. While current AMA policy does address the use of tobacco by the motion picture industry, it does not mention tax incentives (or the lack of eligibility for tax incentives for production companies that depict smoking in movies). Your Reference Committee suggested the title be changed to reflect the intent of the resolution. While your Reference Committee recommends adoption, concern was raised for how incentives called for this resolution would be determined, particularly for films that “unambiguously” portray the health consequences of tobacco use.

(7) BOARD OF TRUSTEES REPORT 21 - COMBATING OBESITY WITH PHYSICAL EDUCATION REQUIREMENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 21 be amended by substitution to read as follows:

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 412-A-11 and the remainder of the report be filed.

1. That the following AMA Policies be reaffirmed:

H-170.999 Health Instruction and Physical Education in Schools
H-470.996 School and College Physical Education
H-470.990 Promotion of Exercise Within Medicine and Society
H-470.989 Physical Fitness and Physical Education
D-440.971 Recommendations for Physician and Community
Collaboration on the Management of Obesity

2. That Policy H-470.975 [Mandatory Physical Education] be amended by insertion and deletion to read as follows:

The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including the handicapped those with physical, developmental, or intellectual challenges or other special needs in grades kindergarten through twelve, including ungraded classes. (Sub. Res. 1, I-88; Reaffirmation and Sunset Report, I-98; Reaffirmation A-07)

3. That Policy H-470.975 be adopted as amended.

HOD ACTION: HOD Policies H-170.999, H-470.996, H-470.990, H-470.989, D-440.971 be reaffirmed and H-470.975 adopted as amended.

This report acknowledges that decreased physical activity has been associated with the obesity epidemic. Decreasing physical activity in schools is due to school, district, and state policies that allow exemptions, but also from school budget cuts and student waivers from physical education courses for participating in other extracurricular activities. The greater issue is not students opting out of physical education classes, but rather schools that may not be requiring physical education. Unintended consequences and barriers as a result of the opt-out could outweigh the resolution's good intentions, to include: increase in primary healthcare provider visits, financial consequences for students and their families, academic concerns, and a disincentive for wellness policies. Current AMA policies recognize the growing obesity epidemic in children and the important role that schools play in fostering long-term healthy lifestyles via quality, comprehensive physical education. While noble in intent, the opt-out provision that would require a parent to get a note from a health professional does not address the barriers to implementing evidence based physical education and activity programs in schools, especially high schools, and places an undue burden on families and the health care provider.

Your Reference Committee did not receive any virtual testimony on this report, however it did receive live testimony in support of this report. Your Reference Committee agreed with testimony requesting the term "handicapped" in Policy H470.975 be changed to universal terminology. Your Reference Committee agrees with the recommendations and acknowledged that addressing this issue requires a comprehensive strategy, to include policies and programs that provide opportunities to be more physically active. Existing AMA policies appropriately recognize the growing obesity epidemic and the important role that school physical education programs can play in fostering healthier lifestyles and behaviors, particularly for children.

- (8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 -
ADVERSE HEALTH EFFECTS OF NIGHTTIME LIGHTING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Science and Public Health Report 4 be amended by insertion and deletion on line 35 to read as follows:

Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night ~~the risk of cancer, and exacerbation of chronic diseases.~~ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 4 adopted as amended and the remainder of the report filed.

This report, a Council initiative, evaluates the impact of artificial lighting on human health, primarily through disruption of circadian biological rhythms or sleep, as well as the impact of headlamps, nighttime lighting schemes, and glare on driving safety. Concerns related to energy cost, effects on wildlife and vegetation, and esthetics also are briefly noted. The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed:
That our American Medical Association:

1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency. (New HOD Policy)
2. Recognizes that exposure to excessive light-at-night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment. (New HOD Policy)
3. Supports the need for further multidisciplinary research on occupational and environmental exposure to light-at-night, the risk of cancer, and exacerbation of chronic diseases. (New HOD Policy)
4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place. (New HOD Policy)
5. That Policy H-135.937 be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee received testimony from the Council on Science and Public Health which supported the recommendations in this report to establish AMA policy addressing the adverse impact of artificial lighting on human health, primarily through disruption of circadian biological rhythms or sleep, as well as the impact of headlamps, nighttime lighting schemes, and glare on driving safety. There were recommendations during the live testimony to ensure that physicians have access to research related to the benefits and risks to make an informed decision regarding light-at-night. Your Reference Committee concurred with this suggestion.

(9) RESOLUTION 401 - REDUCTION OF ONLINE BULLYING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 401 be amended by insertion and deletion on line 17 to read as follows:

RESOLVED, That our American Medical Association urge social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging. ~~cyberbullying and cyberhate.~~ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 401 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 401 be changed to read as follows:

REDUCTION OF ELECTRONIC AGGRESSION

HOD ACTION: Resolution 401 adopted as amended with a change in title.

Resolution 401 asks that our American Medical Association urge social networking platforms to adopt Terms of Service that define and prohibit cyber bullying and cyberhate.

Your Reference Committee received virtual and live testimony in support of this resolution and agrees that such bullying is harmful to today's youth. Live testimony suggested the need to add "including but not limited to that occurring through" to further clarify the fact that technology is constantly growing. It was

suggested that the proper terminology for describing cyberbullying and cyberhate is “electronic aggression”, which is encompassing of all electronic devices and related modes of communication. Your Reference Committee was supportive of this amendment.

(10) RESOLUTION 404 - HELMET SAFETY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 404 be adopted to read as follows:

HOD ACTION: Substitute Resolution 404 adopted.

Athletic Helmets: 1. Our AMA urges the Consumer Product Safety Commission and other appropriate agencies and organizations to establish standards to ensure that athletic and recreational equipment produced or sold in the United States provide protection against head and facial injury. 2. Our AMA: (a) supports requiring the use of head and facial protection by children and adolescents while engaged in potentially dangerous athletic and recreational activities; (b) encourages the use of head and facial protection for adults while engaged in potentially dangerous athletic and recreational activities; (c) encourages physicians to educate their patients about the importance of head and facial protection while engaged in potentially dangerous athletic and recreational activities; and (d) encourages the availability of rental helmets at all commercial settings where potentially dangerous athletic and recreational activities take place. (Modify Current HOD Policy)

Resolution 404 asks that AMA Policy H-470.974 be amended by insertion and deletion to read as follows:

Athletic Helmets: 1. Our AMA urges the Consumer Product Safety Commission to establish standards that athletic and recreational helmets, including but not limited to football, baseball, hockey, horse back riding, bicycle and motorcycle riding, lacrosse, and skiing, produced or sold in the United States provide protection against head injury; and that the AMA advocate the use of appropriate and safe clear face guards as a permanent installation on the current bilateral ear protective batter's helmet to be worn by all baseball and softball players as required safety equipment in all organized baseball and softball for those children from 5 to 44 18 years of age; that the AMA encourage the use of protective helmets and face shields to be worn by all baseball and softball pitchers in organized leagues from 5 to 18 years of age. 2. Our AMA: (a) supports legislation requiring the use of helmets by children ages 17 and younger while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing, ~~or~~ and snowboarding; (b) encourages the use of helmets in adults while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing ~~or~~ and snowboarding; (c) encourages physicians to educate their patients about the importance of helmet use while engaged in potentially dangerous athletic activities, including but not limited to sledding, skiing and snowboarding; and (d) encourages the availability of rental helmets at all commercial sledding, skiing and snowboarding areas. (Modify Current HOD Policy)

Your Reference Committee received virtual and live testimony in favor of the amendments proposed in this resolution regarding AMA Policy H-470.974. Opposing testimony challenged the policy by stating, “this resolution does not go far enough, it should be more of a universal recommendation.” Others stated, “it only scratches the surface.” It was suggested that the second point (2a) of the policy be amended to change the age from 17 to 18. Your Reference Committee was supportive of all the recommendations and agrees with elimination of a minimum and maximum age for helmet safety, since this is an important aspect of injury prevention for everyone.

- (11) RESOLUTION 405 - TOBACCO SALES AMENDMENT
RESOLUTION 420 – AMEND AMA POLICY ON TOBACCO SALES IN PHARMACIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy D-495.994 be amended by insertion and deletion in lieu of Resolutions 405 and 420 to read as follows:

D-495.994 Oppose Sale of Tobacco Products in Pharmacies

Our AMA: (1) specifically and publicly opposes the sale and marketing of tobacco products, including cigarettes, in pharmacies; (2) will communicate with appropriate federal agencies, including the bureau of alcohol, tobacco and firearms, many public health groups, various pharmacy trade groups, and media outlets, in seeking their help in removing tobacco products, including cigarettes, from pharmacy shelves; and (3) will work to pass legislation at the local, state and federal levels to accomplish the goal of banning tobacco sales in pharmacies nationwide; (4) work with Federation members and national organizations concerned about tobacco use to develop a recognition program for pharmacies that voluntarily agree to eliminate the sale of tobacco; (5) work with state and local medical societies to disseminate information on these recognized pharmacies to their membership; and (6) work through its Advocacy Resource Center to provide that list to organizations interested in preventive healthcare. (Sub. Res. 419, A-09; Reaffirmed in lieu of Res. 422, A-10; Reaffirmed in lieu of Res. 426, A-10)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy D-495.994 be adopted as amended.

HOD ACTION: HOD Policy D-495.994 adopted as amended in lieu of Resolutions 405 and 420.

Resolution 405 asks that our American Medical Association (1) work with federation members and national organizations concerned about tobacco use to develop a recognition program for pharmacies that voluntarily agree to eliminate the sale of tobacco, (2) work with state and local medical societies to disseminate information on these recognized pharmacies to its membership, and (3) work through its Advocacy Resource Center to provide that list to organizations interested in preventive healthcare.

Resolution 420 asks that our American Medical Association (1) work with federation members and national organizations concerned about tobacco use to develop a recognition program for pharmacies that voluntarily agree to eliminate the sale of tobacco, (2) work with state and local medical societies to disseminate information on these recognized pharmacies to its membership, and (3) work through its Advocacy Resource Center to provide that list to organizations interested in preventive healthcare.

Your Reference Committee received limited testimony, but significant testimony in support of this was received during the live hearing. It was noted that the content of the two resolutions is identical. The titles of the two resolutions seemed to suggest the intent to amend current policy as opposed to introducing new policy. Your Reference Committee did express concern about the definition of a “pharmacy”, as well as the potential costly fiscal note for such an endeavor. It was also suggested that such an endeavor should address all forms of tobacco. Your Reference Committee appreciated the intent of the resolution

as being a complementary approach to legislative action, and recommended amendment of AMA Policy D-495.994 in lieu of Resolutions 405 and 420.

- (12) RESOLUTION 409 - AMA SUPPORT FOR BREASTFEEDING
RESOLUTION 410 – AMA SUPPORT FOR BREASTFEEDING
WORKING MOTHERS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-245.982 be amended by insertion and deletion to read as follows:

H-245.982 AMA Support for Breastfeeding

Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the ~~2005~~ 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. (2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottlefeeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by

consultation with a physician. (3) Our AMA: (a) support the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period. (CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-245.982 be adopted as amended in lieu of Resolutions 409 and 410.

HOD ACTION: HOD Policy H-245.982 adopted as amended in lieu of Resolutions 409 and 410.

Resolution 409 asks that our American Medical Association (1) recognize that breastfeeding is the optimal form of nutrition for most infants, (2) endorse the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices, (3) support the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities, (4) affirm that mothers nursing babies should not be singled out and discouraged from nursing their infants in public places, (5) endorse implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated, and (6) recommend exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant.

Resolution 410 asks that our American Medical Association (1) recommend the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants, and (2) encourage employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

Your Reference Committee received limited virtual testimony, and significant live testimony. The testimony was favorable and in support of combining the resolutions. The American Academy of Family Physicians (AAFP) and the American College of Obstetricians and Gynecologists (ACOG) provided additional policy and guidelines in support of the resolution. The Committee agreed that breastfeeding has many positive effects for infants, and that it is important for nursing mothers to be supported in their places of work. Given the similarity and overlap of the two resolutions to AMA Policy H-245.982, your

Reference Committee felt it was appropriate to amend current policy in lieu of adopting new policy. It was acknowledged that AMA Policy H-245.982 endorses the American Academy of Pediatrics (AAP) 2005 policy statement on breastfeeding and that it should be amended to include the AAP 2012 update to that policy statement. Your Reference Committee appreciates the submission of the additional policy and guidelines from AAFP and ACOG, but at this time it is unable to address if our AMA should endorse their guidelines at this time given that they have not been reviewed.

(13) RESOLUTION 413 – SETTING DOMESTIC AND INTERNATIONAL PUBLIC HEALTH PREVENTION TARGETS FOR PER CAPITA ALCOHOL CONSUMPTION AS A MEANS OF REDUCING THE BURDEN ON NON-COMMUNICABLE DISEASES ON HEALTH STATUS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 413 be amended by deletion of the fourth resolve on lines 43-48 to read as follows:

RESOLVED, That our American Medical Association continue to address the role of alcohol use on health status and the impact of behaviorally-associated chronic illnesses (including obesity, diabetes, heart disease, chronic respiratory diseases, and many cancers) on the overall burden of disease and the costs of health care services in America (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage federal health services planning agencies and public health authorities to address the role of alcohol and tobacco consumption on health and to promote environmental interventions including evidence based tobacco control and alcohol control policies to improve the health status of Americans (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the World Health Organization to continue its work on the impact of Non Communicable Diseases (NCDs) on health status and to include targets for reduced per capita alcohol consumption among its major proposed interventions in developed and developing nations to reduce the incidence of, prevalence of, and rates of disability and premature deaths attributable to chronic non-communicable diseases (New HOD Policy); and be it further

~~RESOLVED, That, given the data available on the clear links between population data on alcohol consumption and a variety of health indicators, our AMA shall work with the office of the Surgeon General to assure that in the next edition of the Healthy People 2020 report produced by the US Department of Health and Social Services, there will be included targets on reduction of alcohol consumption per capita among US citizens ages 15 and older. (Directive to Take Action)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 413 be adopted as amended.

HOD ACTION: Resolution 413 adopted as amended.

Resolution 413 asks that our AMA (1) continue to address the role of alcohol use on health status and the impact of behaviorally-associated chronic illnesses (including obesity, diabetes, heart disease, chronic respiratory diseases, and many cancers) on the overall burden of disease and the costs of health care services in America; (2) encourage federal health services planning agencies and public health authorities to address the role of alcohol and tobacco consumption on health and to promote environmental interventions including evidence based tobacco control and alcohol control policies to improve the health status of Americans; (3) encourage the World Health Organization (WHO) to continue its work on the impact of non communicable diseases on health status and to include targets for reduced per capita alcohol consumption among its major proposed interventions in developed and developing nations to reduce the incidence of, prevalence of, and rates of disability and premature deaths attributable to chronic non-communicable diseases; and (4) given the data available on the clear links between population data on alcohol consumption and a variety of health indicators, our AMA shall work with the office of the Surgeon General to assure that in the next edition of the *Healthy People 2020* report produced by the US Department of Health and Social Services, there will be included targets on reduction of alcohol consumption per capita among US citizens ages 15 and older.

Your Reference Committee heard limited but supportive testimony for the first 3 resolves. Testimony cited recent studies linking moderate alcohol consumption (1-2 drinks per day) with increased cancer risk in women (*JAMA*; 306:1884-1890; *JNCI*; 2009;101;281). In support of the second resolve, testimony from the US Public Health Service noted that the *Guide to Community Preventive Services* (www.thecommunityguide.org/alcohol) recommends a number of policy and environmental strategies for preventing excessive alcohol use. A strong scientific base exists for addressing the role of alcohol and tobacco consumption on health and for promoting environmental interventions including evidence-based tobacco control and alcohol control policies to improve health status. Strong evidence also exists to support the third resolve, which calls for reducing per capita alcohol consumption among WHO targets on non-communicable diseases (resolve 3). Your Reference Committee concurs with testimony that the fourth resolve fails to recognize the number of objectives already devoted to alcohol use in *Healthy People 2020* (<http://www.healthypeople.gov/2020/topicobjectives2020/default.aspx>) and feels this resolve detracts from the overall resolution.

(14) RESOLUTION 418 - MILD TRAUMATIC BRAIN INJURY AWARENESS**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 418 be amended by insertion and deletion on lines 11-12 to read as follows:

RESOLVED, That our American Medical Association promote awareness that even ~~minor~~ mild cases of traumatic brain injury may have serious and prolonged consequences. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 418 be adopted as amended.

HOD ACTION: Resolution 418 adopted as amended.

Resolution 418 asks that our American Medical Association promote awareness that even minor cases of traumatic brain injury (TBI) have serious and prolonged consequences.

Your Reference Committee received unanimously supportive virtual and live testimony for this resolution. It was noted that head injuries may present special problems and challenges, especially for sports participants and military personnel. One speaker provided evidence of the difference between sport concussion and mild traumatic brain injury in support of this resolution. Your Reference Committee agreed with testimony that our AMA should not take the position that all mild head injuries result in serious and prolonged consequences, and therefore recommended an amendment by adding the word "may". However it was noted that with considerable attention now being devoted to the issue of TBI, the potential long-term consequences of even seemingly mild head injuries should be highlighted. Such efforts should dovetail with advocacy for the use of helmets. Your Reference Committee recommended this resolution be adopted with amendments which better match the title and articulate the issue.

(15) RESOLUTION 421 - ADVOCATING FOR DISCLOSURE OF NICOTINE LEVEL PER CIGARETTE AT POINT OF SALE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends the following Substitute Resolution 421 be adopted:

HOD ACTION: HOD Policy H-495.989 not amended and HOD Policy H-495.981 reaffirmed.

RESOLVED, that Policy H-495.989 be amended by deletion to read as follows:

Our AMA: (1) supports working toward more explicit and effective health warnings regarding the use of tobacco (and alcohol) products, including the extension of labeling requirements of ingredients to tobacco products sold in the United States; (2) supports legislation or regulations that require (a) tobacco companies to accurately label their products indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" and (3) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets. (CSA Rep. 3, A-04); and be it further

RESOLVED, that Policy H-495.981 be reaffirmed.

Resolution 421 asks that our American Medical Association advocate for the introduction of legislation which will require tobacco companies to accurately label their products specifically indicating the nicotine content of their products (including cigarettes) in easily understandable and meaningful terms consistent with Policy H-495.989, Tobacco Product Labeling.

Your Reference Committee did not receive any virtual testimony on this resolution; however, live testimony supported the intent of the resolution while citing existing policy which more appropriately captured the intent of the resolution. Testimony indicated a lack of any valid methods for measuring the nicotine content in tobacco products which appear to be in conflict with item 2(a) in policy H-495.989. Testimony indicated that the language in Resolution 421 specifying the nicotine content of tobacco products could be more harmful than beneficial. Your Reference Committee agrees with testimony that information about attempts to label the tar and nicotine in tobacco products be considered for inclusion in the Annual Tobacco Report to the HOD or other information vehicle as appropriate.

Policy recommended for reaffirmation:

H-495.981 Light and Low-Tar Cigarettes

Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine: (a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years. (b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand. (d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers. (e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting. (f) Advertising and promotion of low tar cigarettes were intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands. (g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation. (h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette. Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products. (CSA Rep. 3, A-04)

(16) RESOLUTION 425 - HEAD INJURY PREVENTION IN HOCKEY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 425 be amended by deletion on line 1 to read as follows:

RESOLVED, That our American Medical Association ~~seek federal legislation that would~~ encourage that all levels of hockey effectively prevent head hits and dangerous checking. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 425 be adopted as amended.

HOD ACTION: Resolution 425 adopted as amended.

Resolution 425 asks that our American Medical Association seek federal legislation that would encourage that all levels of hockey effectively prevent head hits and dangerous checking.

Your Reference Committee received virtual and live testimony in support of this resolution, however some of the testimony questioned if seeking federal legislation was the best approach to address this issue. Your Reference Committee concurred that state athletic organizations and sports agencies would be better suited to make lasting and enforceable change and therefore decided to remove the language about federal legislation.

(17) RESOLUTION 426 - PREVENTION OF OBESITY THROUGH INSTRUCTION IN PUBLIC SCHOOLS**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 426 be amended by insertion and deletion on lines 14-15 to read as follows:

RESOLVED, That our American Medical Association

- (1) urge state and federal government appropriate agencies to, and
- (2) support legislation that would:
require ~~a minimum of four hours of~~ meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools, and that our AMA encourage physicians to volunteer their time to assist with such an effort. (Directive to take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 426 be adopted as amended.

HOD ACTION: Resolution 426 adopted as amended.

Resolution 426 asks that our American Medical Association urge state and federal government to require a minimum of four hours of yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools, and that our AMA encourage physicians to volunteer their time to assist with such an effort.

Your Reference Committee received virtual testimony that supported the notion of nutrition education while also cautioning against assigning a number of hours to the amount of said instruction. Live testimony was mixed. While the author stressed the need for a clear number of nutrition education hours, testimony cautioned against assigning a number of hours arbitrarily. Also, testimony noted that this topic should be addressed at the state or local levels. In light of this testimony, your Reference Committee recommends adoption of the resolution as amended.

(18) RESOLUTION 428 - GAMES AND HEALTH PROMOTION**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 428 be amended by insertion and deletion on lines 19-20 to read as follows:

RESOLVED, That our American Medical Association ~~Council on Science and Public Health~~ review and report on health related use of electronic games, types of games that are available, and games that could be recommended by physicians for targeted patient populations.
(Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 428 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 428 be changed to read as follows:

ELECTRONIC GAMES AND HEALTH PROMOTION

HOD ACTION: Resolution 428 adopted as amended with a change in title.

This resolution asks that our American Medical Association Council on Science and Public Health review and report on health related use of games, types of games that are available and games that could be recommended by physicians for targeted patient populations.

Your Reference Committee did not receive any virtual testimony. However there was limited live testimony in support of the resolution which noted that the growing field of electronic gaming may lend itself to improved health of patients. Testimony did point out that a particular Council should not be identified within the resolve given that it is the decision of the AMA Board of Trustees to determine the course of further study. Therefore your Reference Committee recommends that Resolution 428 be amended to remove language citing the Council on Science and Public Health. Also, your Reference Committee agreed that it was important to amend language in order to make clear that this resolution addresses "electronic" gaming in the title and body, to distinguish from other forms of games.

- (19) RESOLUTION 403 - STIGMATIZATION OF MENTAL HEALTH DISORDERS
RESOLUTION 411 - ENDING DISCRIMINATION AGAINST PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS
RESOLUTION 414 - APPLICANTS FOR LICENSURE, HOSPITAL PRIVILEGES, PROFESSIONAL SOCIETY MEMBERSHIP, AND SPECIALTY BOARD CERTIFICATION BY PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS
RESOLUTION 429 - ENDING DISCRIMINATION AGAINST PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS
RESOLUTION 431 - APPLICANTS FOR LICENSURE, HOSPITAL PRIVILEGES, PROFESSIONAL SOCIETY MEMBERSHIP AND SPECIALTY BOARD CERTIFICATIONS BY PHYSICIANS PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 403, 411, 414, 429, and 431 be referred for decision.

HOD ACTION: Resolutions 403, 411, 414, 429, and 431 referred for decision.

Resolution 403 asks that our American Medical Association (1) investigate how the stigmatization of mental health disorders in medical professionals by medical professionals has developed and persists; and (2) address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or encouraging programming to promote awareness about and reduce this stigmatization. (Directive to Take Action)

Resolution 411 asks that our American Medical Association (1) advocate that physicians who experience medical board disciplinary action as a result of their actions associated with a diagnosed substance use disorder (SUD), but who are fully compliant with their Physician Health Program (PHP) monitoring contracts requiring total abstinence from any use of alcohol or other drug of abuse, with verification via intensive and comprehensive monitoring, are considered to be alcohol- and drug- free, and should not be arbitrarily subject to increased professional liability insurance premiums, removal from health insurance provider panels, loss of hospital credentials and privileges, loss of professional society membership, and loss of specialty board certification, solely on the basis of public medical board actions taken on their license what were related to their diagnosed SUD, (2) support the Federation of State Medical Board's (FSMB) "Impaired Physician Guidelines" of April 2011 which encourage state medical licensure boards to make full use of the option of referring physicians with diagnosed SUDs or mental disorders to their state PHP in lieu of taking adverse/public disciplinary action on said physician's license, and (3) support the principles outlined in the public policy statements of the American Society of Addiction Medicine on professionals with potentially impairing illness and consistently speak out against discrimination against physicians with potentially impairing SUDs and mental disorders.

Resolution 414 asks that our American Medical Association advocate the removal of language on application forms for initial licensure, credentialing, membership, or certification or for renewal of licensure, credentials, membership, or certification which require, without individualized cause, the applicant to declare the presence of a diagnosis of substance use disorder, treatment for substance use disorder, or participation in a state Physician Health Program.

Resolution 429 asks that our American Medical Association (1) advocate that physicians who experience medical board disciplinary action as a result of behavior associated with a diagnosed Substance Use Disorder (SUD) but are fully compliant with their Physician Health Program (PHP) contracts requiring total abstinence from any use of alcohol or other drug of abuse that is verified by intensive and comprehensive monitoring not be arbitrarily subject to increased liability premiums, removal from insurance provider panels, loss of hospital credentials and privileges, loss of professional society membership and loss of specialty board certification based solely on public medical board actions taken on their license that were related to their diagnosed SUD, and (2) support the Federation of State Medical Board's "Impaired Physician Guidelines" of April 22, 2011 which encourage state medical licensure boards to make full use of the option of referring physicians with diagnosed SUDs or a mental disorder to their state PHP in lieu of taking adverse/public disciplinary action on said physician's license.

Resolution 431 asks that our American Medical Association advocate for the removal of language on application forms for initial medical licensure, hospital credentialing, specialty medical society membership, specialty certification or for renewal of licensure, credentials, membership, or certification which, absent individualized cause, require the applicant to declare the presence of a diagnosis of Substance Use Disorder, treatment for Substance Use Disorder or participation in a state Physician Health Program.

Your Reference Committee received limited but supportive virtual testimony for the above resolutions. The live testimony was substantial and expressed support for addressing the discrimination and stigmatization of physicians and physicians-in-training as it relates to current or former impairment. There was considerable debate over the issues raised in Resolutions 414 and 431 given the sensitive nature of the disclosure of impairment, weighing the stigma of diagnosis, impact that such disclosure could have on a physician's professional career, and the impact on patient trust. Your Reference Committee is very sensitive to the physician health concerns brought forth in Resolutions 403, 411, 414, 429, and 431, agreeing that they are all of a similar nature and warrant further consideration in sum. Many of the issues addressed in these resolutions are being considered by the Federation of State Physician Health

Program (FSPHP)-AMA Task Force and FSMB Special Committee on Physician Reentry for Formerly Impaired Physicians. Therefore your Reference Committee has recommended that these resolutions be referred to the Board of Trustees for decision.

(20) RESOLUTION 415 - TASKFORCE ON MEDICAL DISASTER
RESPONSE AND INDIGENT CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 415 be referred for decision.

HOD ACTION: Resolution 415 referred for decision.

Resolution 415 asks that our American Medical Association (1) form a taskforce to collect information about, and address, coordination issues among existing medical disaster response teams and plans, including those of state component medical societies, hospitals, the medical reserve, and federal and state-sponsored disaster medical assistance teams, (2) that this AMA taskforce work to define the AMA's and local medical societies' roles in response to a disaster; that it prepare recommendations for improved coordination among the various teams and plans that involve physician participation and that it investigate liability coverage issues for participating physicians, and (3) that this AMA taskforce also address the separate issue of physicians volunteering to fill unmet medical needs of indigent persons, including liability coverage for physician volunteers.

While your Reference Committee received mixed virtual testimony, overwhelming testimony was heard in the live hearing in support of the actions called for in this resolution. Your Reference Committee supports the intent of this resolution but questions whether one task force could effectively address the wide and disparate range of issues cited in the three resolves. Your Reference Committee also agrees with the testimony of one speaker in the live hearing who supported the resolution but questioned whether the large cost to implement this resolution is a prudent use of our limited AMA resources. This is particularly relevant in light of our AMA's recent transition out of this topic area as part of our new strategic direction.

Virtual testimony noted that the resolution seems to call for actions that could be addressed by our Disaster Medicine Caucus, as well as by other national agencies and organizations. Also, it mixes the issues of disaster response and care for the indigent. Regarding the second Resolve, it was noted that issues of liability coverage are separate from the coordination and medical society involvement issues. In the non-disaster context, liability coverage rights for physicians volunteering to fill unmet medical needs of indigent persons are typically different on a state-to-state basis. The AMA has several policies related to disaster response and recommends physician attention and activity in this area to enhance disaster preparedness and response capabilities of both civilian and military providers. Policy H-160.961 addresses the requests in the third Resolve by encouraging all physicians to share in providing care for the poor, and Policy H-160.965 urges that all jurisdictions provide physicians with protection from liability for uncompensated care for the indigent.

Live testimony cited the important need for our AMA to continue to support efforts of medical students and physicians to prepare for, respond to, and recover from disasters and public health emergencies. This is critically important for those who wish to deploy as volunteers on organized medical response teams. Our AMA should continue to have a role in helping to coordinate state and national efforts to ensure an integrated medical response to mass casualty events. Based on the positive and spirited support for this resolution, your Reference Committee feels that the most appropriate action is to refer the resolution to the Board for further deliberation and direction. This includes discussion of the effort called for in this resolution, as well as to redefine our AMA's role in the field of disaster medicine and public health preparedness as we embark on a new strategic direction.

(21) BOARD OF TRUSTEES REPORT 2 – ANNUAL UPDATE ON
ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2011
THROUGH FEBRUARY 2012

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends the recommendations in Board of Trustees Report 2 be not adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 2 not adopted and the remainder of the report filed.

This annual report includes information on national tobacco use rates, trends in usage and actions taken by government and health agencies to address tobacco use and its social, economic and health effects. The report also details our AMA's actions and activities in this area. The Board believes that an annual tobacco report to the House is no longer necessary, as is currently required under Policy D-490.983. AMA staff will continue to monitor tobacco issues and provide the Board of Trustees with tobacco-related updates as new issues arise.

The Board of Trustees recommends that Policy D-490.983 be rescinded and the remainder of this report be filed.

Your Reference Committee received limited virtual testimony; however, there was significant testimony against the elimination of the annual tobacco report. Testimony expressed that tobacco use continues to be a leading cause of death in the U.S. and therefore warrants the ongoing attention of the AMA. Such testimony was in favor of our AMA increasing its efforts to address tobacco prevention and cessation, and to consider tobacco control as a priority of our AMA as it develops its "health outcomes" measures for the new AMA strategic direction.

(22) RESOLUTION 427 - PROVIDING PHYSICAL FITNESS GUIDELINES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 427 not be adopted.

HOD ACTION: Resolution 427 referred.

Resolution 427 asks that our American Medical Association (1) coordinate with the appropriate national specialty societies to seek the development of a jointly endorsed checklist designed to help identify underlying risk factors in patients interested in beginning or resuming physical fitness activities, (2) offer non-legal guidance regarding the liability associated with signing releases for patients' participation in physical fitness activities, and (3) maintain a current resource for its members as data becomes available regarding evidence based recommendations that would be appropriate for their patients.

Your Reference Committee received limited virtual and live testimony for this resolution. Your Reference Committee acknowledged the importance of physical activity for long-term health and quality of life, as well as the challenges that physicians face when asked to sign a patient release form for physical activity. However it was agreed that the requests in the first and second resolve go beyond the scope of our AMA. Also, it was suggested that there are Federation members who already address the third resolve, making this a duplicative effort. Your Reference Committee appreciated the intent of the resolution, but upon hearing no compelling evidence in support of the resolution it is recommended that Resolution 427 not be adopted.

(23) RESOLUTION 432 – AGE-BASED ALCOHOL POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 432 not be adopted.

HOD ACTION: Resolution 432 not adopted.

Resolution 432 asks our American Medical Association to engage in discussion regarding federal and state age-based alcohol policies, including review of the positive and negative consequences of these policies and ways to reduce harm from age appropriate and underage drinking; and that such discussion include review of the research literature and other appropriate evidence in light of the recent increase in underage binge drinking and adverse consequences of underage binge drinking.

Your Reference Committee heard testimony supporting both sides of this issue. Speakers emphasized that the use of alcohol by individuals under the age of 21 is a significant global problem, which requires assessment of strategies to protect young people from the harm associated with alcohol. While your Reference Committee encourages our AMA to participate in national dialogue on this subject, no compelling evidence was heard to single out a reduction in the legal drinking age as a preferred solution. Our AMA has numerous policies to support the minimum legal drinking age of 21 years of age. Your Reference Committee agrees with testimony that the literature does not support returning to a lower drinking age. The fiscal note may be much higher than suggested to implement this resolution. Lacking a strong evidence base, your Reference Committee recommends against adoption to avoid any potential misinterpretation that current age-based AMA alcohol policy is under scrutiny.

(24) RESOLUTION 433 – PREVENTING DEATHS AND INJURIES FROM DISTRACTED WALKING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 433 not be adopted.

HOD ACTION: Resolution 433 adopted.

RESOLVED, That our American Medical Association, as a champion of public health, include distracted walking as one of the preventable hazards in its published and distributed materials on lifestyle medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA utilize established channels of communication with internal and external media to increase public awareness of the hazards caused by distracted walking (Directive to Take Action); and be it further

RESOLVED, That our AMA write to appropriate federal and state agencies encouraging them to reevaluate the safety of the roads and intersections for the walking public in their respective jurisdictions (Directive to Take Action); and further

RESOLVED That our AMA report back at the 2013 Annual Meeting summarizing actions which are likely to make walking safer for our people. (Directive to Take Action)

Resolution 433 asks that our AMA (1) include distracted walking as one of the preventable hazards in its published and distributed materials on lifestyle medicine; (2) utilize established channels of communication with internal and external media to increase public awareness of the hazards caused by distracted walking; (3) write to appropriate federal and state agencies encouraging them to reevaluate the safety of the roads and intersections for the walking public in their respective jurisdictions; and (4) report back at the 2013 Annual Meeting summarizing actions that are likely to make walking safer.

Your Reference Committee heard limited testimony on the resolution. While the resolution is well-intended, no published evidence was presented to support the requested actions. Considering our new strategic direction, your Reference Committee has concerns about limited resources for this resolution.

(25) RESOLUTION 412 - REAFFIRMING COMMITMENT TO PHYSICIAN HEALTH AND WELLBEING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-405.961, H-275.949, D-405.992, and D-405.990 be reaffirmed in lieu of Resolution 412

HOD ACTION: HOD Policies H-405.961, H-275.949, D-405.992, and D-405.990 reaffirmed in lieu of Resolution 412.

Resolution 412 asks our American Medical Association (1) reaffirm its commitment to physician health and wellbeing and combat discrimination against physicians who have potentially impairing health conditions for which they have received treatment and been involved in ongoing monitoring by a state Physician Health Program, (2) reaffirm AMA Policy D-405.992 (A-08) by which this House of Delegates considers the concept of physician wellness as an element of the AMA Strategic Plan, (3) reaffirm Policy D-405.990, and (4) recommend that the Federation of State Medical Boards, the Federation of State Physician Health Programs, the American Psychiatric Association, the American Academy of Addiction Psychiatry, the American Society of Addiction Medicine, and the AMA Alliance be invited to join the AMA in a Consortium on Physician and Family Wellbeing that would, among other activities, work to: (a) fully implement AMA Policy D-405.996 (A-03) which calls for a web-based database of information about state and provincial physician health programs in the US and Canada and how physicians, family members, and others can easily access these programs; (b) align policies among the seven organizations to support state Physician Health Programs in their activities to protect the public safety, to reduce the incidence of medical errors and professional liability claims, to advocate as appropriate for physician re-entry into practice after a health condition or its treatment have resulted in a span of time away from practice, and to provide education to physicians, health care provider systems, and the general public regarding the activities and benefits of Physician Health Programs; (c) encourage and assist every medical school accredited by the Liaison Committee on Medical Education to have an operational Student Assistance Program and Faculty Assistance Program to meet the needs of students and faculty and their family members and to provide liaison to and from their relevant state Physician Health Programs; and (d) encourage and assist every state Physician Health Program to have an operational and easily accessible structure and process to support the spouses and life partners of physicians who have a potentially impairing health condition which has affected or could affect the physician's practice, including medical families which have been impacted by physician suicide.

Your Reference Committee received limited and mixed testimony on this resolution. While live testimony requested support of the original request, your Reference Committee discussed the concern for the fiscal note and existing programs already addressing this topic. It was noted that our AMA has been very active in the field of physician health and wellness to include a number of recent activities and products. Your Reference Committee commends this work and supports the intent of the resolution. However it was identified that our AMA has numerous policies regarding physician health and wellness. The first resolve is covered by policy H-405.961 which "affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness", and

by Policy H-275.949 which “opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance coverage, specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation or enrolled in a state-wide physician health program.” The second resolve asks for reaffirmation of Policy D-405.992. The third resolve asks for reaffirmation of AMA Policy D-405.990. The fourth resolve asks for the formation of a new Consortium on Physician and Family Wellbeing. Your Reference Committee was informed that the issues raised in the fourth resolve are already being addressed by the Federation of State Medical Boards (FSMB) Special Committee on Physician Reentry for Formerly Impaired Physicians, as well as by the Federation of State Physician Health Programs (FSPHP)-AMA Task Force. It was explained that the FSPHP already maintains a database of existing state PHPs and related information. Your Reference Committee was concerned that such a Consortium would be a duplication of existing efforts and contain a high fiscal note. Therefore your Reference Committee recommended that Policies H-405.961, H-275.949, D-405.992, and D-405.990 be reaffirmed in lieu of Resolution 412.

Policies recommended for reaffirmation:

H-405.961 Physician Health Programs

Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness. (CSAPH Rep. 2, A-11)

H-275.949 Discrimination Against Physicians Under Supervision of Their Medical Examining Board

1. Our AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance coverage, specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation or enrolled in a state-wide physician health program. 2. Our AMA will communicate Policy H-275.949 to all specialty boards and request that they reconsider their policy of exclusion where such a policy exists. (Sub. Res. 3, A-92; Reaffirmed: BOT Rep. 18, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 925, I-11)

D-405.992 Physician Health and Wellness

Our AMA: (1) supports programs related to physician health and wellness, including those offered in conjunction with the Federation of State Physician Health Programs; (2) will convene those interested in medical education in an effort to bring the dialogue about healthy lifestyle and balance early in the careers of medical students and residents; and (3) considers the concept of physician wellness as an element of the AMA Strategic Plan. (Res. 609, A-08)

D-405.990 Educating Physicians About Physician Health Programs

1. Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability of state physician health programs and services to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. 2. Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness. 3. Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs. (Res. 402, A-09; Modified: CSAPH Rep. 2, A-11)

(26) **RESOLUTION 434 – AMA’S SUPPORT FOR EVIDENCE BASED OBESITY PREVENTION STRATEGIES**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-150.953, H-440.902, D-470.993 be reaffirmed in lieu of Resolution 434.

HOD ACTION: HOD Policies H-150.953, H-440.902, D-470.993 reaffirmed in lieu of Resolution 434.

Resolution 434 asks that our AMA (1) help promote evidence-based initiatives by the Centers for Disease Control and Prevention and others to attack our nation's obesity epidemic; (2) support initiatives and legislative efforts providing tax incentives or tax credits to developers who include environmentally friendly features in their developments such as walking trails, playgrounds, bike paths and sidewalks that create opportunities for residents of all ages to exercise and help combat obesity and many chronic illnesses; and (3) report back at the 2014 Annual Meeting the progress made in its efforts to reduce obesity across our nation.

Your Reference Committee heard limited but supportive testimony for this resolution. Your Reference Committee concurs with testimony that our AMA should take a leadership role in working to identify, evaluate, and implement safe and effective strategies to prevent obesity in all ages and populations. This includes advancing evidence-based policies that impact health outcomes and medical practice. Several existing policies speak to the spirit and intent of this resolution. While some testimony was heard expressing support for tax incentives and tax credits as means to promote physical activity, such strategies are supported by existing Directive D-470.993.

Policies recommended for reaffirmation:

H-440.902 Obesity as a Major Health Concern

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10)

H-150.953 Obesity as a Major Public Health Program

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired

weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10)

D-470.993 Government to Support Community Exercise Venues

Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. (Res. 423, A-04)

(27) RESOLUTION 435 – HEALTHY MEALS FOR CHILDREN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-150.935 be reaffirmed in lieu of Resolution 435.

HOD ACTION: HOD Policy H-150.935 reaffirmed in lieu of Resolution 435.

Resolution 435 asks that our AMA encourage appropriate entities to promote voluntary adherence to appropriate nutritional standards in accordance with best scientific information for meals marketed specifically to children.

No testimony was heard on this resolution. Rather than create new policy, your Reference Committee believes that current Policy H-150.935 adequately captures the spirit and intent of this resolution.

Policy recommended for reaffirmation:

H-150.935 Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility

Our AMA: 1) supports and encourages corporate social responsibility in the use of marketing incentives that promote healthy childhood behaviors, including the consumption of healthy food in accordance with federal guidelines and recommendations; and 2) encourages fast food restaurants to establish competitive pricing between less healthy and more healthy food choices in children's meals. (Sub. Res. 402, A-11)

Reference Committee E (Science and Technology)

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - CSAPH
SUNSET REVIEW OF 2002 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations contained in Council on Science and Public Health Report 1 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted and the remainder of the report filed.

Council on Science and Public Health Report 1 contains recommendations for retention, modification, or rescission of science, medical technology, and public health policies last considered in 2002. It recommends that House of Delegates policies that are listed in the Appendix to the report be acted upon in the manner indicated in the Appendix and the remainder of the report be filed.

In the absence of any testimony noting disagreements with the Council's recommendations for handling policies eligible for sunset review, your Reference Committee recommends that the report be adopted as submitted.

- (2) RESOLUTION 501 - 9/11 EARLY RESPONDER HEALTH COVERAGE
OF CANCER

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 501 be adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 501 be changed to read as follows:

STUDY OF CANCER INCIDENCE IN 9/11 RESPONDERS

HOD ACTION: Resolution 501 adopted with a change in title.

Resolution 501 asks that our American Medical Association encourage further study of the association between post-September 11, 2001 World Trade Center attack exposure and cancer incidence.

Your Reference Committee heard testimony strongly in support of this resolution. Testimony stated that recognition of cancer by physicians in individuals who responded to the 9/11 terrorist attacks is necessary to ensure that requisite health care services and treatments are provided to those affected individuals. Additional testimony took a broader view and generalized this resolution to look into exposure and related health effects of first responders and disaster response personnel in their daily emergency responses. Testimony also suggested that a title change was needed to better reflect the need for further study of the causal association between the incidence of cancer and the 9/11 terrorist attacks. Onsite testimony noted recently published information regarding a new rule proposed by federal health officials which will expand the World Trade Center Health Program to include coverage of 50 types of cancer.

(3) BOARD OF TRUSTEES REPORT 20 - ENHANCING ANTIBIOTIC STEWARDSHIP TO IMPROVE PATIENT OUTCOMES IN THE INPATIENT SETTING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 20 be amended by insertion and deletion on lines 13-15, to read as follows:

1. That our American Medical Association (AMA) support antimicrobial stewardship programs, ~~which should be~~ overseen by qualified physicians, as an effective way to ensure appropriate antibiotic use, to optimize patient outcomes, and to reduce overall ~~healthcare~~ costs for a healthcare facility. Antibiotic stewardship programs are multi-faceted approaches to optimize antibiotic prescribing, encompassing components such as policy, guidelines, surveillance, education, epidemiology of current resistance, and process measurement. Successful antibiotic stewardship programs monitor and direct antimicrobial use, providing a standard, evidence-based approach to judicious antibiotic use in a healthcare facility. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 20 be adopted as amended, and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 20 adopted as amended, and the remainder of the report filed.

Board of Trustees Report 20 provides an introduction to the concept of antibiotic stewardship within a health care facility, describes recommended elements for such an antibiotic stewardship program, and discusses process-related and outcome-related measurements that can be used to evaluate antibiotic stewardship programs. It recommends that our AMA (1) support antimicrobial stewardship programs, which should be overseen by qualified physicians, as an effective way to ensure appropriate antibiotic use, to optimize patient outcomes, and to reduce overall health care costs for a health care facility; (2) support the development of antibiotic stewardship programs that allow flexibility so that adherence to national requirements does not limit the ability of providers to design programs based on local variables, such as health care facility size, and to address local antimicrobial stewardship and infection prevention challenges; (3) urge each health care facility's governing body to promote and support robust antimicrobial stewardship and infection prevention programs as critical components of assuring safe patient care; and (4) support continued research into the impact of antibiotic stewardship programs on process outcomes, and encourage increased research on the impact of such programs on patient-centered outcomes.

Your Reference Committee heard mostly supportive testimony, noting that institutions should be allowed to decide how to implement their own programs, and that the programs should be overseen by well-trained physicians. Testimony was split on whether stewardship programs should be mandatory, but those who supported mandates stated that they were not unhappy with the current recommendations. The Board of Trustees offered language clarifying the definition of an antibiotic stewardship program, and stated that an Appendix was inadvertently left out of the report published in the Handbook, which will be filed with the report. Your Reference Committee recognizes the importance of antibiotic stewardship programs and is generally supportive of this report, with the inclusion of the definition of an "antibiotic stewardship program" in the first recommendation.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 –
LABELING OF BIOENGINEERED FOODS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Recommendation in Council on Science and Public Health Report 2 be amended by insertion and deletion on lines 34-50, to read as follows:

Bioengineered (Genetically Modified-Engineered) Crops and Foods
... (4) Our AMA supports ~~efforts for the mandatory pre-market systematic safety assessments of genetically modified bioengineered foods~~ and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in ~~genetically modified bioengineered~~ foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens. The FDA is urged to remain alert to new data on the health consequences of bioengineered foods and update its regulatory policies accordingly.

(5) Our AMA supports continued research into the potential consequences to the environment of ~~genetically modified bioengineered~~ crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; ~~and~~ (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests; and (e) assessment of the agricultural impact of bioengineered foods, including the impact on farmers.

... (7) Our AMA ~~recognizes that the~~ urges government, industry, consumer advocacy groups, and the scientific and medical communities ~~have a responsibility~~ to educate the public and improve the availability of unbiased information and research activities on ~~genetically modified bioengineered foods and of research activities.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendation in Science and Public Health Report 2 be adopted as amended and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted as amended and the remainder of the report filed.

Council on Science and Public Health Report 2 reviews the potential adverse health effects of bioengineered foods, and implications for labeling are addressed. It recommends that H-480.958 “Genetically Modified Crops and Foods” be amended by insertion and deletion as follows:

Bioengineered (Genetically Modified-Engineered) Crops and Foods

- (1) Our AMA recognizes the continuing validity of the three major conclusions contained in the 1987 National Academy of Sciences white paper "Introduction of Recombinant DNA-Engineered Organisms into the Environment." [The three major conclusions are: (a) There is no evidence that unique hazards exist either in the use of rDNA techniques or in the movement of genes between unrelated organisms; (b) The risks associated with the introduction of rDNA-engineered organisms are the same in kind as those associated with the introduction of unmodified organisms and organisms modified by other methods; (c) Assessment of the risk of introducing rDNA-engineered organisms into the environment should be based on the nature of the organism and the environment into which it is introduced, not on the method by which it was produced.]
- (2) That federal regulatory oversight of agricultural biotechnology should continue to be science-based and guided by the characteristics of the plant or animal, its intended use, and the environment into which it is to be introduced, not by the method used to produce it, in order to facilitate comprehensive, efficient regulatory review of new ~~genetically modified~~ bioengineered crops and foods.
- (3) Our AMA believes that as of ~~December 2009~~ June 2012, there is no scientific justification for special labeling of ~~genetically modified~~ bioengineered foods, as a class, and that voluntary labeling is without value unless it is accompanied by focused consumer education.
- (4) Our AMA supports ~~efforts for the~~ mandatory pre-market systematic safety assessments of ~~genetically modified~~ bioengineered foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in ~~genetically modified~~ bioengineered foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens.
- (5) Our AMA supports continued research into the potential consequences to the environment of ~~genetically modified~~ bioengineered crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; and (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests.
- (6) Our AMA recognizes the many potential benefits offered by ~~genetically modified~~ bioengineered crops and foods, does not support a moratorium on planting ~~genetically modified~~ bioengineered crops, and encourages ongoing research developments in food biotechnology.
- (7) Our AMA recognizes that the government, industry, and the scientific and medical communities have a responsibility to educate the public and improve the availability of unbiased information and research activities on ~~genetically modified~~ bioengineered foods and of research activities. (CSA Rep. 10, I-00; Modified: CSAPH Rep. 1, A-10) (Modify Current HOD Policy)

Lengthy testimony was received virtually and onsite, both in support of the Council's recommendation and in opposition to it. Those who offered support believe that the Council based its recommendation on the best available science. The FDA currently does not have the authority to mandate labeling if bioengineered foods are not materially different in safety or nutritional profile. To strengthen the FDA's oversight, the Council recommended that pre-market safety testing be mandatory so that consumers are confident that the foods they eat are safe. Others testifying believe that strong consumer desire for labeling should outweigh uncertainties in the science and limitations in the regulatory policy. Your Reference Committee appreciates these diverse views and the fervent advocacy of consumers who are opposed to bioengineered foods, and proposes amendments to the Council's recommendation that urge continued attention to data on the health effects of bioengineered foods and assessment of their

agricultural impact. The amendments also urge all stakeholders to educate the public using scientific and unbiased sources.

(5) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 6 –
SCREENING MAMMOGRAPHY

RECOMMENDATION A:

1. Our AMA ~~a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer, while also recognizing that there are small, but not inconsequential, harms risks associated with it, including false positive results and overdiagnosis~~

b. Recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.

~~strongly endorses the positions of the American College of Obstetrics and Gynecology, the American Cancer Society, and the American College of Radiology that all women have screening mammography as per current guidelines.~~

2. Our AMA ~~c. favors participation in and support of the efforts of the professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations.~~

3. Our AMA ~~d. advocates remaining alert to new epidemiological findings regarding screening mammography age-specific breast cancer mortality reduction following mammography screening as well as associated harms.~~ 4. Based on recent summary data our AMA recommends annual screening mammograms and continuation of clinical breast examinations in asymptomatic women 40 years and older. 5. Our AMA ~~and~~ encourages the periodic reconsideration of these recommendations as more epidemiological data become available.

~~e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography. Physicians should regularly discuss with their individual patients whether screening mammography is appropriate for them. This discussion should include reminders about the benefits and harms of mammography, an update of the patient's family history, consideration of other breast cancer risk factors, and the mammography recommendations of various medical organizations, in particular where these recommendations differ between organizations.~~

~~f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.~~

~~e.g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer, and to consider other education on the identification of risk factors for breast cancer, including the value of taking a thorough family history to detect red flags~~

~~for hereditary cancer, so that recommendations for screening will be appropriate.~~

~~f. h. supports insurance coverage for screening mammography.~~

~~6. Our AMA ~~e. i.~~ supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.~~

~~7. Our AMA ~~h. j.~~ reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians. (Modify HOD Policy)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendation in Council on Science and Public Health Report 6 be adopted as amended and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 6 adopted as amended and the remainder of the report filed.

Council on Science and Public Health Report 6 highlights current screening mammography guidelines, explores the established benefits and harms of mammography, reviews the process by which the USPSTF developed its updated recommendations on screening mammography, and updates the AMA's current policy recommendations. It recommends that Policy H-525.993 "Mammography Screening in Asymptomatic Women Forty Years and Older" be amended by insertion and deletion as follows:

Screening Mammography Screening in Asymptomatic Women Forty Years and Older Our AMA:

~~1. Our AMA a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer, while also recognizing that there are small, but not inconsequential, harms associated with it, including false positive results and overdiagnosis strongly endorses the positions of the American College of Obstetrics and Gynecology, the American Cancer Society, and the American College of Radiology that all women have screening mammography as per current guidelines.~~

~~2. Our AMA b. favors participation in and support of the efforts of the professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations.~~

~~3. Our AMA c. advocates remaining alert to new epidemiological findings regarding age-specific breast cancer mortality reduction following mammography screening as well as associated harms.~~
~~4. Based on recent summary data our AMA recommends annual screening mammograms and continuation of clinical breast examinations in asymptomatic women 40 years and older.~~
~~5. Our AMA and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.~~

~~d. believes that beginning at the age of 40 years, all women should be eligible for screening mammography. Physicians should regularly discuss with their individual patients whether screening mammography is appropriate for them. This discussion should include reminders about the benefits and harms of mammography, an update of the patient's family history, consideration of other breast cancer risk factors, and the mammography recommendations of various medical organizations, in particular where those recommendations differ between organizations.~~

~~e. encourages physician education on the identification of risk factors for breast cancer, including the value of taking a thorough family history to detect red flags for hereditary cancer.~~

~~f. supports insurance coverage for screening mammography.~~

- ~~6. Our AMA g. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid, and trustworthy.~~
- ~~7. Our AMA h. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians. (Modify HOD Policy)~~

Testimony offered congratulations to the Council for a well-done report. Many comments were fully supportive of the Council's recommendation, while many suggested the report be referred back to the Council so that it could consider emerging data on digital mammography. In virtual testimony, the American College of Radiology (ACR) offered several amendments. The Council thanked the ACR for its detailed suggestions, and suggested that some be incorporated into the recommendation. The Council opposed referral, noting along with several others that new evidence is always emerging, and therefore recommendations should periodically undergo revisions. The Council believes that its report covers the state of the evidence at this point in time and has included in its recommendation that it will remain alert to new epidemiological data and revisit its recommendation as such data emerge. Your Reference Committee concurs, and believes that the revisions offered by the Council are reasonable. Your Reference Committee also believes that because physicians often discuss "risks and benefits" with their patients, that the word "harm" should be replaced.

- (6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 7 - DRUG SHORTAGES UPDATE
RESOLUTION 509 – REGULATORY RELIEF TO END AMERICA'S DRUG SHORTAGES
RESOLUTION 510 – SHORTAGES OF NON-NARCOTIC SCHEDULE II MEDICATIONS DUE TO DEA AND FDA CONTROLS
RESOLUTION 524 – EFFECTIVE ACTION TO END CRITICAL DRUG SHORTAGES
RESOLUTION 525 – REASSESSMENT OF "AVERAGE PRICE FORMULA" PLUS 6% OF CMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Council on Science and Public Health Report 7 be amended by insertion and deletion on page lines 9-42, to read as follows:

1. Our AMA supports the recommendations of the 2010 Drug Shortage Summit convened by the American Society of Health System Pharmacists, American Society of Anesthesiologists, American Society of Clinical Oncology and the Institute for Safe Medication Practices and work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports requiring all manufacturers of Food and Drug Administration approved drugs and, including FDA approved drugs with recognized off-label uses, to give the agency advance notice (~~within at least 6 months prior~~ or otherwise as soon as practicable) of anticipated voluntary or involuntary, permanent or temporary, discontinuance of the manufacture or marketing of such a product. ~~drug shortage legislation such as H.R. 2245 and S. 296 that would require manufacturers, including those who share the market with others, to notify the FDA of any discontinuance, interruption, or adjustment in the manufacture of a drug that may result in a shortage.~~
3. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections, and the review of manufacturing

changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

~~34. Our AMA will express appreciation to the President of the United States for issuing an Executive Order intended to assist in mitigating ongoing drug shortages supports the creation of a task force to enhance the HHS Secretary's response to preventing and mitigating drug shortages and to create a strategic plan to: (a) enhance interagency coordination; (b) address drug shortage possibilities when initiating regulatory actions (including the removal of unapproved drug products from the market); (c) communicate with stakeholders; and (d) consider the impact of drug shortages on research and clinical trials address ongoing aspects of drug shortages.~~

45. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

~~56. The Council on Science and Public Health will continue to evaluate the drug shortage issue and keep the HOD informed about AMA efforts to address this problem report back on progress made in addressing drug shortages at the 2012 Interim Meeting of the House of Delegates. will report back at the 2012 Annual Meeting on efforts to mitigate drug shortages, including the evaluation of potential economic and regulatory factors that may contribute to drug shortages, especially with respect to oncologic drugs.~~

~~67. Our AMA publicly declares the problem of unsafe and unverifiable medicines and medicine shortages a national public health emergency. (CSAPH Rep. 2, I-11). Our AMA urges the development of a comprehensive federal independent report on the root causes of drug shortages. Such an analysis should include consider federal actions, the number of manufacturers, economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing.~~

8. Our AMA urges that procedures be put in place: (1) for the FDA to monitor the availability of Schedule II controlled substances; (2) for the FDA to identify the existence of a shortage that is caused or exacerbated by existing production quotas; and, (3) for expedited DEA review of requests to increase aggregate and individual production quotas for such substances.

9. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

10. Our AMA urges Congress to amend the 2003 Medicare Modernization Act to allow for more reasonable payment rates for prescription drugs.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Science and Public Health Report 7 be adopted as amended in lieu of Resolutions 509, 510, 524, and 525, and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 7 adopted as amended in lieu of Resolutions 509, 510, 524, and 525, and the remainder of the report filed.

Council on Science and Public Health Report 7-A-12 reviews the drug shortage issue and recommends several amendments to existing AMA Policy H-100.956 as follows:

1. Our AMA supports the recommendations of the 2010 Drug Shortage Summit convened by the American Society of Health System Pharmacists, American Society of Anesthesiologists, American Society of Clinical Oncologists and the Institute for Safe Medication Practices and work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports requiring all manufacturers of Food and Drug Administration approved drugs to give the agency advance notice (within 6 months or otherwise as soon as practicable) of anticipated voluntary or involuntary, permanent or temporary, discontinuance of manufacture or marketing of such a product ~~drug shortage legislation such as H.R. 2245 and S. 296 that would require manufacturers, including those who share the market with others, to notify the FDA of any discontinuance, interruption, or adjustment in the manufacture of a drug that may result in a shortage.~~
3. Our AMA ~~will express appreciation to the President of the United States for issuing an Executive Order intended to assist in mitigating ongoing drug shortages~~ supports the creation of a task force to enhance the HHS Secretary's response to preventing and mitigating drug shortages and to create a strategic plan to address ongoing aspects of drug shortages.
4. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible.
5. The Council on Science and Public Health continue to evaluate the drug shortage issue and keep the HOD informed about AMA efforts to address this problem ~~will report back at the 2012 Annual Meeting on efforts to mitigate drug shortages, including the evaluation of potential economic and regulatory factors that may contribute to drug shortages, especially with respect to oncologic drugs.~~
6. Our AMA ~~publicly declares the problem of unsafe and unverifiable medicines and medicine shortages a national public health emergency~~ urges the development of a comprehensive federal report on the root causes of drug shortages. Such an analysis should include economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. (CSAPH Rep. 2, I-11)

Resolution 509 asks that to resolve our national drug shortage, our American Medical Association, through legislation and/or regulatory relief seek improved drug manufacturing by (1) removing imposed production impediments that have no proven benefit for patients; (2) ensuring that well-established drugs are not removed from the market due to newly created compliance standards unless such removal is clearly required for significant and obvious safety reasons; (3) ending government price controls on medications; and (4) streamlining the process of approval of new medications and modifications to existing medications. (Directive to Take Action).

Resolution 510 asks that our American Medical Association work with the US Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA), and other agencies of the federal government to monitor the availability of non-narcotic Schedule II medications including methylphenidate related pharmaceuticals, evaluating the distribution of the various compounds and brands, as well as

regional shortages, and that our AMA encourage the federal government through its many agencies, specifically the DEA and FDA, to assure adequate supplies of methylphenidate related pharmaceuticals in the marketplace in all regions of the country.

Resolution 524 asks that our American Medical Association advocate for innovative, effective and prompt actions by the US Congress to fix this all important and emergent problem of critical drug shortages with consequences such as weakening or jeopardizing continued patent protection and Food and Drug Administration approval of critical drugs unavailable for more than 30 days during any given year, except for circumstances beyond a manufacturer's control and that our AMA report back on progress made on fixing the issue of critical drug shortage at the 2012 Interim Meeting of the House of Delegates.

Resolution 525 asks that our American Medical Association petition the Centers for Medicare & Medicaid Services (CMS) to investigate whether the "average price formula" plus 6% over cost for reimbursement of generic drugs has a negative impact on the market for generic drugs as an etiology for unintended drug shortages, and that our AMA notify CMS that generic chemotherapy drugs cannot be delivered to pediatric patients for "cents of profit" for oncology practices to stay financially solvent.

The Council on Science and Public Health offered several amendments to its report to incorporate salient features of Resolutions 509, 510, 524, and 525. All testimony reinforced the seriousness of the current situation of drug shortages, but also with the recognition that this was a complex problem. Frustration with the lack of an obvious immediate solution was evident in requests for the AMA to develop an action plan that would somehow address this issue. All things considered, your Reference Committee agrees with the attempt by the Council to address many elements of the other Resolutions and to offer a more complete, relevant and workable AMA policy on this subject. The Committee also offers two additional recommendations to append to the Council report addressing regulatory relief and concerns about the role of federal payment practices in this public health crisis. These recommendations address the requests or urgent action on the part of our AMA.

(7) RESOLUTION 502 - REDUCED INCARCERATION AND IMPROVED TREATMENT OF INDIVIDUALS WITH MENTAL ILLNESS OR ILLICIT DRUG DEPENDENCE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-430.997 be amended by insertion, to read as follows:

H-430.997 Standards of Care for Inmates of Correctional Facilities
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-430.997 be adopted as amended in lieu of Resolution 502.

HOD ACTION: HOD Policy H-430.997 adopted as amended in lieu of Resolution 502.

Resolution 502 asks that our American Medical Association amend Policy H-430.989 by insertion and deletion as follows:

H-430.989 Disease Prevention and Health Promotion in Correctional Institutions: Our AMA urges state and local health departments to develop plans that would foster closer working relations

between the criminal justice, medical, and public health systems toward 1. the prevention and control of HIV/AIDS, substance abuse, tuberculosis and hepatitis, 2. the management and treatment of psychiatric disorders such as drug dependence, and 3. a reduction in reincarceration rates related to drug abuse and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, ~~and~~ drug treatment center staff and psychiatric care center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs, as well as inpatient or outpatient psychiatric treatment programs, as a sentence or in connection with sentencing. (Modify Current HOD Policy)

Limited testimony was offered on Resolution 502, supporting its adoption and intent. Some recommended modifications to the resolve, while another recommended an amendment to Policy H-430.997. Although substance misuse and dependence, as well as other psychiatric disorders can be problematic, many other illnesses also are prevalent in correctional facilities and are associated with significant morbidity (see CSAPH Report 4, A-11). Your Reference Committee believes that an amendment to Policy H-430.997 sufficiently achieves the intent of the resolution.

(8) RESOLUTION 503 - PROMOTING PREVENTION OF FATAL OPIOID OVERDOSE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy D-95.987 be amended by insertion and deletion to read as follows:

D-95.987 ~~Intranasal~~ Naloxone Administration for Prevention of Opioid Overdose

Our AMA: (1) recognizes the great burden that ~~opiate~~ opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients ~~with opiate addiction; and~~ (2) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (3) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (4) will continue to monitor the progress of such intranasal naloxone studies initiatives and respond as appropriate report back as needed. (Res. 526, A-06)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy D-95.987 be adopted as amended in lieu of Resolution 503.

HOD ACTION: HOD Policy D-95.987 adopted as amended in lieu of Resolution 503.

Resolution 503 asks that our American Medical Association (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.

Your Reference Committee is aware that the CDC recently reported on the implementation and partial success of several community based programs offering naloxone and other opioid overdose prevention services to persons who use drugs, their families and friends, and service providers (e.g., health-care

providers, first responders, homeless shelters, and substance abuse treatment programs). These services include education regarding overdose risk factors, recognition of signs of opioid overdose, appropriate responses to an overdose, and administration of naloxone. Onsite testimony was supportive of the Virtual Reference Committee's recommendation and support was offered for reconsideration of the 2nd resolve from the original resolution. Given the complex issues involved in addressing opioid overdoses from illegal, as well as prescription drug products, your Reference Committee offers support for the continued implementation and analysis of such programs in order to best inform public and AMA policy. It believes that amendment of current policy achieves the intent of the resolution and captures the need for further educational efforts.

(9) RESOLUTION 504 - REGULATIONS ON THE PATENTING OF ENDOGENOUS HUMAN DNA

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-140.855 be amended by insertion and deletion to read as follows:

H-140.855 Gene Patents and Accessibility of Gene Testing Our AMA: (1) opposes patents on ~~human genes and their~~ naturally-occurring human DNA or RNA sequences ~~mutations~~; (2) supports legislation requiring that existing gene patents be broadly licensed so as not to limit access through exclusivity terms, excessive royalties or other unreasonable terms; and (3) supports legislation that would exempt from claims of infringement those who use patented genes for medical diagnosis and research. (Res. 526, A-10)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-140.855 be adopted as amended in lieu of Resolution 504.

HOD ACTION: HOD Policy H-140.855 adopted as amended in lieu of Resolution 504.

Resolution 504 asks that our American Medical Association oppose the patenting of endogenously occurring human DNA or RNA sequences, including specific alleles of such sequences found anywhere within the human population, or DNA and RNA products derived from these sequences.

Your Reference Committee received testimony fully supportive of the intent of this resolution. However, your Reference Committee is concerned that the last phrase in the resolve, i.e., "or DNA and RNA products derived from these sequences" is overly broad, since it would apply to therapeutic products that are based on DNA or RNA sequences, such as biologic drugs. The patentability of such products is without question, and your Reference Committee does not believe that was the intent of the resolution. Further, current AMA policy is not opposed to the patenting of products, but instead opposed to the patenting of human sequences that occur in nature. Testimony also suggested changing the word "endogenously" to "naturally" since some may not know the definition of "endogenous" and since "naturally-occurring" is the term of art used in current litigation on gene patenting. Your Reference Committee believes that the amendment it has proposed to H-140.855 addresses the intent of the resolution.

(10) RESOLUTION 507 – 2013: THE YEAR OF THE ULTRASOUND

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 507 be adopted.

DIAGNOSTIC ULTRASOUND UTILIZATION AND EDUCATION

RESOLVED, That our AMA affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians. (New HOD Policy)

RESOLVED, That our AMA support the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. (New HOD Policy)

HOD ACTION: Substitute Resolution 507 adopted.

Resolution 507 asks that our American Medical Association (AMA) (1) proclaim 2013 the Year of Ultrasound; (2) support the educational efforts and widespread integration of ultrasound throughout the entire continuum of medical education; and (3) recognize those responsible for 2013: The Year of Ultrasound and acknowledge their many efforts to promote ultrasound as safe, effective, and affordable.

Multiple sponsors were associated with this resolution. An amendment was introduced by one of the sponsors and garnered considerable support. Others questioned why this type of resolution was before the HOD as many other diagnostic modalities and treatments also have gained widespread acceptance. On the other hand, some practice gaps may continue to exist in the application of ultrasound technologies. Ultimately, your Reference Committee recommends adopting a substitute resolution.

(11) RESOLUTION 508 - DEVICE (PACEMAKER, ICD) SHELF LIFE AND EXPIRATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 508 be amended by insertion and deletion on line 19, to read as follows:

RESOLVED, That our American Medical Association encourage the US Food and Drug Administration to clearly define and interpret the definition and meaning of the “use before date.” for medical devices.
(Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 508 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 508 be changed to read as follows:

MEDICAL DEVICE “USE BEFORE DATES”

HOD ACTION: Resolution 508 adopted as amended with a change in title.

Resolution 508 asks that our American Medical Association encourage the US Food and Drug Administration to clearly define and interpret the definition and meaning of the “use before date.”

Virtual testimony was supportive of this resolution, stating that practitioners have noticed that devices will properly function beyond the “use before” date that has been applied to the device. A goal of decreasing

health care costs and providing more patients with access to devices without delay also was noted, supporting the need for further clarification regarding the “use before” date, including clinical and fiscal impacts. Limited onsite testimony supported the recommendation of the Virtual Reference Committee. Although testimony noted that the FDA would not necessarily object to the recommendation of the Virtual Committee, standardization of “use before” dates could limit the Agency’s flexibility in clearing/approving medical devices. Inasmuch as this was not the intent of the resolution, your Reference Committee supports this resolution and agrees benefit would derive from clarification of the “use before” date by the FDA. Testimony also supported a change in title so that it is applicable to medical devices.

(12) RESOLUTION 513 - TRICLOSAN ANTIMICROBIAL SOAP

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 513 be amended by insertion and deletion on lines 25-30, to read as follows:

~~RESOLVED, That our American Medical Association recognize the toxicity and potential adverse health and environmental effects of Triclosan-containing products and endorse efforts to eliminate this chemical from consumer and health care products. (Directive to Take Action); and be it further~~

RESOLVED, That our AMA encourage the Food and Drug Administration to finalize the triclosan antimicrobial monograph first drafted in 1978 and updated in 1994 which found evidence for the safety and effectiveness of only alcohol and iodine-based topical products in health care use (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the education of members on the issue of the importance of proper hand hygiene and the preferential use of plain soap and water or alcohol-based sanitizers in health care settings, consistent with the recommendations of the Centers for Disease Control and Prevention. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 513 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 513 be changed to read as follows:

TRICLOSAN ANTIMICROBIALS

HOD ACTION: Resolution 513 adopted as amended with a change in title.

Resolution 513 asks that our American Medical Association (1) recognize the toxicity and potential adverse health and environmental effects of triclosan-containing products and endorse efforts to eliminate this chemical from consumer and health care products; (2) encourage the Food and Drug Administration to finalize the antimicrobial monograph first drafted in 1978 and updated in 1994 which found evidence for the safety and effectiveness of only alcohol and iodine-based topical products in health care use; AND (3) encourage the education of members on the issue of the importance of proper hand hygiene and the

preferential use of plain soap and water or alcohol-based hand sanitizers in health care settings, consistent with the recommendations of the Centers for Disease Control and Prevention.

Your Reference Committee heard testimony that was both supportive of the resolution but also not supportive because of the limited view of the use of triclosan as an antimicrobial added to soaps (as triclosan is used in many consumer products). The FDA testified that triclosan is one of many antiseptic products under consideration in the current over-the-counter (OTC) drug review which was noted as a very large and complex undertaking. The FDA reiterated their stance that triclosan is not currently known to be hazardous to humans, and until the OTC review has been completed, the resolution could not be supported. However, the same testimony also noted that several studies have raised concerns regarding endocrine disruption in animals, but that this does not necessarily mirror triclosan's effects in humans.

Your Reference Committee accepts that the FDA is currently in the process of completing its assessment of the safety of triclosan in consumer products and believes that this process should be allowed to run its course before adopting the points of view raised in Resolve 1. Your Reference Committee believes that because triclosan is not found as an antimicrobial additive only in soaps, a title change eliminating the word "soap" would better fulfill the resolution's determination. Therefore your Reference Committee recommends that the first Resolve be deleted, the word "triclosan" be added to the second resolve and the remainder of the resolution adopted with a change in title.

(13) RESOLUTION 514 - SYNTHETIC GASIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 514 be amended by insertion and deletion on lines 29-31 to read as follows:

RESOLVED, That our American Medical Association encourage the study of the health effects of clean coal technologies including synthetic gasification plants and report back to the AMA House of Delegates at its 2013 Annual Meeting. (~~Directive to Take Action~~)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 514 be adopted as amended.

HOD ACTION: Resolution 514 adopted as amended.

Resolution 514 asks that our American Medical Association study the health effects of clean coal technologies including synthetic gasification plants and report back to the AMA House of Delegates at its 2013 Annual Meeting.

Limited but supportive testimony was offered on this resolution. Onsite testimony clarified that this resolution was triggered by potential activities at a specific coal plant in Illinois. Federal study is currently underway on this issue. Your Reference Committee acknowledges the importance of this issue to public health and the need for further study, but does not believe that an AMA study represents a wise use of our resources.

(14) RESOLUTION 515 – MODERNIZATION OF THE FEDERAL TOXIC SUBSTANCES CONTROL ACT (TSCA) OF 1976

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 515 be amended by insertion and deletion on line 25, to read as follows:

RESOLVED, That our American Medical Association support modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies ~~the~~ reasonable authority to regulate hazardous chemicals. (New HOD Policy); and be it further

RESOLVED, That our AMA support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public (New HOD Policy); and be it further

RESOLVED, That our AMA work with members of the AMA federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH). (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 515 be adopted as amended.

HOD ACTION: Resolution 515 adopted as amended.

Resolution 515 asks that our American Medical Association (AMA) (1) support modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies the authority to regulate hazardous chemicals; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and (3) work with members of the AMA federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorization, and Restriction of Chemicals (REACH).

Virtual testimony was generally supportive, but some testimony supported reaffirmation of existing AMA policy, while others stated that reaffirmation would be inadequate, preferring to enhance existing policy through the resolves. It also noted enhancements that would include placing more responsibility on manufacturers to provide chemical safety information, provide greater transparency concerning safety, and standardize with European Union chemical safety directives. Onsite testimony spoke strongly to the need to address federal authority to regulate hazardous chemicals. Despite more than 62,000 chemicals being grandfathered by TSCA in 1976 and thousands more subsequently introduced into commerce, only five hazardous chemicals have been successfully removed from the market by the EPA since 1990. Even though some concerns may exist about excessive regulations and their effects on commerce, your Reference Committee is convinced that a more reasonable process for protecting U.S. citizens from chemical hazards must be in place.

- (15) RESOLUTION 517 - CAUSE THE UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF) TO SEEK APPROPRIATE PHYSICIAN SPECIALTY SOCIETY INPUT AND TO BE SUBJECT TO TRANSPARENCY AND APPEAL
RESOLUTION 527 – ENCOURAGE THE AMA TO SEEK CONSTRUCTIVE INPUT TO THE DELIBERATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE BY REQUIRING REPRESENTATION BY SPECIALTY SOCIETIES SPECIFIC TO THE CLINICAL AREA UNDER REVIEW BY USPSTF

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 517 be adopted in lieu of Resolutions 517 and 527.

HOD ACTION: Substitute Resolution 517 adopted in lieu of Resolutions 517 and 527.

RECOMMENDATIONS BY THE USPSTF

RESOLVED, That our American Medical Association expresses concern regarding recent recommendations by the United States Preventive Services Task Force (USPSTF) on screening mammography and prostate specific antigen (PSA) screening and the effects these USPSTF recommendations have on limiting access to preventive care for Americans. (New HOD Policy)

RESOLVED, That our AMA encourage the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policies H-410.955 and H-410.967 be reaffirmed.

HOD ACTION: HOD Policies H-410.955 and H-410.967 reaffirmed.

Resolution 517 asks that our American Medical Association (1) seek legislation and/or regulations to ensure that the United States Preventive Services Task Force (USPSTF) consult with the appropriate physician specialty societies when considering recommendations for a specific disease condition before issuing dictums that impact good medical practice; (2) seek legislation and/or regulations to ensure that the USPSTF be made subject to the same controls that apply to all other federal agencies insuring transparency, fairness and balance including that the USPSTF be subject to the Administrative Procedures Act which requires notice and comment process before its recommendations can go into effect; and (3) express a lack of confidence in the decisions of the USPSTF unless its recommendations reflect the input of relevant physician specialty societies and its activities are conducted in a transparent, fair and balanced manner.

Resolution 527 asks that our American Medical Association (AMA) (1) reject the US Preventive Services Task Force (USPSTF) recommendations against PSA screening until conflicting evidence can be properly reconciled by the appropriate specialty; (2) challenge any USPSTF recommendations that do not include the medical experts specific to the clinical area under review; (3) meet with the USPSTF governing body for the purpose of establishing a protocol through which physician specialists may join USPSTF panels as

consultants to render input in their area of specialty; and (3) report back to the House of Delegates at the 2013 Annual Meeting regarding their discussions with the USPSTF.

Your Reference Committee received mixed testimony on this item, with some strongly supporting the resolutions, some strongly opposing them, and some supporting referral for study of the USPSTF process. Your Reference Committee acknowledges the concerns shared by many in the physician community regarding the USPSTF's process and recommendations. It commends the USPSTF for implementing the "TOPS" program, a process by which stakeholders can participate in topic groups to provide input on recommendation development. Your Reference Committee also notes that current AMA policy supports the inclusion of specialists on task forces (H-410.955) and states that USPSTF recommendations should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care (H-410.967). Your Reference Committee believes that adoption of the substitute resolution, along with reaffirmation of current policy, sends a strong statement about concerns, while offering support for USPSTF programs that are intended to be inclusive of specialists.

Policies recommended for reaffirmation:

H-410.955 Physician Representation on Expert Panels

Our AMA encourages government panels and task forces dealing with specific disease entities to have representation by physicians with expertise in those diseases. (Res. 509, A-10)

H-410.967 Guide to Clinical Preventive Services

The AMA: (1) recommends the USPSTF Guide to Clinical Preventive Services to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. The Guide should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines. (CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07)

(16) RESOLUTION 520 - REVISION OF RESUSCITATION POLICIES FOR PREMATURE INFANTS BORN AT THE CUSP OF VIABILITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 520 be adopted in lieu of Resolution 520.

HOD ACTION: Substitute Resolution 520 adopted in lieu of Resolution 520.

GUIDELINES ON NEONATAL RESUSCITATION

RESOLVED, That our American Medical Association support programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability. (New HOD Policy)

Resolution 520 asks that our American Medical Association direct the Council on Science and Public Health to study discouraging rigid guidelines for neonatal resuscitation based solely upon gestational age and birth weight requirements, as well as the promotion of awareness of regional resources, rates of

successful resuscitation, patient prognosis and new developments in methods of care and pediatric/neonatal transport, and support collaborative decision making amongst care givers and the parents of premature infants.

Your Reference Committee received limited but supportive testimony on this item. In 2010, the American Heart Association (AHA) released guidelines on neonatal resuscitation, which your Reference Committee notes do not appear to be rigid. The author of the resolution explained that the reference to “rigid guidelines” was meant to refer to institution-based guidelines, which can differ. The American Academy of Pediatrics administers an educational program based on the AHA recommendations, designed to teach an evidence-based approach to resuscitation of the newborn to providers who care for newborns at the time of delivery. Your Reference Committee believes that education about the guidelines is key, and proposes a substitute resolution based on that belief. Your Reference Committee also believes that if further study is needed on this issue, it would be best accomplished by specialists who care for premature infants.

(17) RESOLUTION 521 - PHYSICIAN AWARENESS AND EDUCATION ABOUT PHARMACEUTICAL AND BIOLOGICAL RISK EVALUATION AND MITIGATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 521 be amended by insertion and deletion on lines 23-27, to read as follows:

RESOLVED, That our American Medical Association work with the pharmaceutical and biological industries to increase physician awareness of Risk Evaluation and Mitigation Strategies Programs as a means to improve patient safety (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the e-prescribing and point of care resource industries to increase physician awareness of Risk Evaluation and Mitigation Strategies Programs as a means to improve patient safety by including current Risk Evaluation and Mitigation Strategy Program information in their products. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 521 be adopted as amended.

HOD ACTION: Resolution 521 adopted as amended.

Resolution 521 asks that our American Medical Association (1) work with the pharmaceutical and biological industries to increase physician awareness of Risk Evaluation and Mitigation Programs as a means to improve patient safety; and (2) work with the e-prescribing and point of care resource industries to increase physician awareness of Risk Evaluation and Mitigation Programs as a means to improve patient safety by including current Risk Evaluation and Mitigation Program information in their products.

The Council on Science and Public Health previously developed a report on Risk Evaluation and Mitigation Strategies (REMS) for the express purpose of informing the HOD about this risk management strategy that is sometimes required by the FDA in order to ensure the safe use of prescription drug products (CSAPH Report 8, A-10). Testimony noted that such programs continue to impact workflow and decision-making in physician practices, and better integration into e-prescribing systems or other point of

care tools would be helpful. Your Reference Committee notes that the proper regulatory term is Risk Evaluation and Mitigation Strategies and has amended the resolution to reflect this fact.

(18) RESOLUTION 523 - APPROPRIATE USE OF ANTIPSYCHOTIC MEDICATIONS IN NURSING HOMES PATIENTS WITHOUT PENALTY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 523 be amended by insertion and deletion on lines 26-31, to read as follows:

RESOLVED, That our AMA meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics ~~are~~ can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed (Directive to Take Action); and be it further

RESOLVED, That our AMA ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 523 be adopted as amended.

HOD ACTION: Resolution 523 adopted as amended.

Resolution 523 asks that our American Medical Association (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics are an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed; and (2) ask CMS to cease and desist in issuing citations or financial penalties for appropriate use of antipsychotics for the treatment of dementia-related psychosis.

CMS has recently developed a national action plan to improve behavioral health and to safeguard nursing home residents from unnecessary drug use called the *CMS National Behavioral Health Quality Initiative*. Among other things, the findings are intended to be used to target and implement treatments to improve the overall management of residents with dementia, including reducing the use of antipsychotic drugs in this population. Resolution 523 is intended to better define what is recognized as conditions of safe and appropriate use of these medications in physician practice. Testimony was unanimously in favor of the intent of the resolution, with suggestions to add small edits that better reflect the role of the physician in directing appropriate care of their patients. Your Reference Committee concurs, and has offered an amended resolution.

(19) RESOLUTION 505 - DIRECT-TO-CONSUMER ADVERTISING OF DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 505 be referred.

HOD ACTION: Resolution 505 referred.

Resolution 505 asks that our American Medical Association pursue legislation or regulation as appropriate to require that direct-to-consumer advertisements for durable medical equipment (DME) and other medical supplies in any media: (1) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; and (2) whenever feasible list the actual criteria (or a summary thereof) from the appropriate Certificate of Medical Necessity; and (3) note that patients who knowingly obtain DME or other supplies without meeting the eligibility criteria and the physicians who inappropriately certify such patients may be subject to civil and/or criminal penalties for fraud; and (4) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items.

Your Reference Committee received testimony supportive of this resolution as well as additional testimony seeking stronger language to place greater responsibility with the patient regarding falsified claims. Testimony stated that requirements for advertising durable medical equipment (DME) to the public should better educate the public on criteria for eligibility in order to receive DME and stress that only a physician or other health care provider can determine this eligibility. Testimony also raised concerns that DME advertising has led to increased health care costs because criteria for eligibility are not specifically stated in advertising. It was also recognized in testimony that direct solicitation of patients via telephone may be contributing to the problem. Your Reference Committee notes that several policies addressing DME exist in the Policy Database, some of which are conflicting. Your Reference Committee is also concerned that the regulations can negatively impact physicians who offer DME. Your Reference Committee appreciates the intent of this resolution, but believes that this topic would benefit from a report examining the resolution in the context of existing policy.

(20) RESOLUTION 511 - MEDICAL VS LEGAL SOLUTIONS TO DRUG ABUSE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 511 be referred.

HOD ACTION: Resolution 511 referred.

Resolution 511 asks that our American Medical Association encourage the federal government to re-examine the enforcement-based approach to illicit drug issues (“war on drugs”) and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease.

The Council on Science and Public Health already is developing a report evaluating the effectiveness of federal drug policies, including an examination of the issues raised in Resolution 511. Testimony supported referral, but a suggestion was made to split the ideas in the resolve so that the statement about treating drug abuse as a public health threat and drug addiction as a preventable and treatable disease could be adopted now. Your Reference Committee notes that the Council report will be considered at I-12, so an integrated policy recommendation covering all aspects of this issue will be presented in only 5 months. It therefore supports referral.

(21) RESOLUTION 512 - NANOPARTICLE TESTING, MONITORING, AND REGULATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 512 be referred.

HOD ACTION: Resolution 512 referred.

Resolution 512 asks that our American Medical Association (1) recognize both the benefits and the potential risks to public health and the environment from the widespread use of nanoparticles; and (2) endorse responsible regulation of existing or new nanoparticles prior to their introduction in industrial or consumer products, such as, but not limited to, standardized research, toxicological testing, biomonitoring and product labeling.

Testimony on this resolution was generally supportive. The need for an appropriate regulatory environment was noted, as well as the uncertainty about the safety of nanomaterials. Concern was raised about the rapid rate of change in this field and the need to focus any report on medically relevant and public health safety issues. Your Reference Committee believes that the House could benefit from a contemporary review of this complex issue and recommends referral.

(22) RESOLUTION 516 - WARNING NEW YORK STATE CITIZENS OF PRODUCTS KNOWN TO CAUSE CANCER, BIRTH DEFECTS, OR OTHER REPRODUCTIVE HARM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 516 not be adopted.

HOD ACTION: Resolution 516 not adopted.

Resolution 516 asks that our American Medical Association study California Proposition 65 which requires warning labels on products to inform citizens about products known to contain chemicals which are carcinogenic or teratogenic and report back to the AMA House of Delegates at the 2013 Annual Meeting regarding the appropriateness of encouraging similar legislation in the United States.

Testimony was mixed on this resolution. Testimony stated that California's Proposition 65 has caused broad additional costs incurred by businesses within California. Other testimony, including that of the Centers for Disease Control, stated that the law has been beneficial to public health. Additional testimony stated uncertainty that a push for a similar nationwide law would best achieve AMA's policy goals. Onsite testimony supported adoption. However, testimony also revealed that California has already conducted a study on the impact of Proposition 65. Additionally, the authors of the testimony believed that a law such as Proposition 65, enacted nationwide, would allow citizens of the United States access to the same information as California residents regarding the carcinogenicity of products and materials they encounter. Ultimately, your Reference Committee does not believe that the study called for in this resolution is within the scope and resources of the AMA, and therefore agreed to recommend that this resolution not be adopted.

(23) RESOLUTION 518 - PAIN AS A MAJOR HEALTH CARE PROBLEM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-120.976, D-160.981, and H-280.958 be reaffirmed in lieu of Resolution 518.

HOD ACTION: HOD Policies D-120.976, D-160.981, and H-280.958 reaffirmed in lieu of Resolution 518.

Resolution 518 asks that our American Medical Association recognize pain as a major health care problem and support all reasonable efforts to promote expanding pain-related educational, research and advocacy opportunities for all health care providers.

The Institute of Medicine recently released a comprehensive report on the issue of chronic pain in America and the AMA already has a substantial policy base surrounding the issue of pain management. Testimony on this item was limited, but supported reaffirmation of existing policy. Your Reference Committee concurs, and recommends reaffirmation of Policies H-280.958, D-160.981, and D-120.976.

The HOD Policies recommended for reaffirmation are:

H-280.958 Pain Control in Long-Term Care

Our AMA will work: (1) to promulgate clinical practice guidelines for pain control in long term care settings and support educational efforts and research in pain management in long term care; and (2) to reduce regulatory barriers to adequate pain control at the federal and state levels for long term care patients. (Res. 715, A-98; Reaffirmed: CSAPH Rep. 2, A-08)

D-160.981 Promotion of Better Pain Care

Our AMA: (1) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; (2) encourages relevant specialties to collaborate in studying the following: (a) the scope of practice and body of knowledge encompassed by the field of pain medicine; (b) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (c) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (d) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic; and (3) will participate in the International Association for the Study of Pain (IASP) International Pain Summit to be held in Montreal, Canada, on September 3, 2010; and encourages the participation of affiliate pain specialty societies, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and other relevant organizations in the IASP Pain Summit. (Res. 321, A-08; Appended: Res. 522, A-10)

D-120.976 Pain Management

Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain). (Res. 809, I-04; Appended: CSAPH Rep. 5, A-06; Appended: CSAPH Rep. 5, A-10)

(24) RESOLUTION 522 - LEAD FREE WHEEL WEIGHTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-135.959 be reaffirmed in lieu of Resolution 522.

HOD ACTION: HOD Policy H-135.959 reaffirmed in lieu of Resolution 522.

Resolution 522 asks that our American Medical Association (1) seek either policy or legislation that would ban lead wheel weights in the United States; and (2) join and support the National Lead Free Wheel Weight Initiative.

Testimony expressed uncertainty of the documentation of the problem of lead wheel weights, but additional testimony recognized the general need to limit exposure of toxic substances in the environment in order to protect public health. In addition, testimony by the resolution's authors concurred with your Reference Committee in supporting reaffirmation of existing AMA policy which specifically concerns lead exposure.

HOD Policy recommended for reaffirmation:

H-135.959 Eliminating Lead, Mercury and Benzene from Common Household Products
Our AMA: (1) supports the development of standards to achieve non-hazardous levels of exposure to lead, mercury, or benzene arising from common household or workplace products; (2) encourages efforts to minimize or eliminate mercury use in hospitals and other health care facilities; and (3) will work in coalitions with appropriate federal agencies and health care organizations to educate physicians and other health care professionals about suitable alternatives to the use of mercury and mercury-containing devices and the appropriate disposal of mercury and mercury-containing devices; (4) encourages efforts to minimize or eliminate lead in all commercial and household products. (Sub. Res. 418, I-92; Appended: Sub. Res. 410, A-00; Reaffirmation I-00; Reaffirmed A-03; Modified: CSAPH Rep. 7, A-10)

(25) RESOLUTION 526 – SUPPORT EPA'S CARBON EMISSIONS STANDARD

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-135.949 and H-135.934 be reaffirmed in lieu of Resolution 526.

HOD ACTION: HOD Policies H-135.949 and H-135.934 be reaffirmed in lieu of Resolution 526.

Resolution 526 asks that our AMA (1) support the Environmental Protection Agency's (EPA's) effort to establish green house gas new source performance standards for fossil fuel electric generating units and (2) oppose any efforts by Congress to delay or impede EPA's authority to issue or enforce regulations on green house gas emissions from fossil fuel electric generating units.

Your Reference Committee heard testimony regarding the importance of protecting the health of the public with regard to emissions, and the consistency of the resolution with current AMA policy. Some concern was expressed about the economic implications of increased regulation, noting that increased energy costs disproportionately affect the poor. Your Reference Committee is in agreement that public health is of utmost importance, but points out that current policy supports meaningful reductions in power plant emissions (H-135.949) and supports the EPA's authority to promulgate rules to regulate and control green house gas emissions (H-135.934).

Policies recommended for reaffirmation:

H-135.949 Support of Clean Air and Power Plant Emissions Act
Our AMA supports federal legislation that meaningfully reduces the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide. (Res. 429, A-03; Reaffirmation I-07)

H-135.934 EPA and Green House Gas Regulation

Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States. (Res. 925, I-10)

Reference Committee F (Governance and Finance)

(1) BOARD OF TRUSTEES REPORT 7 – AMA DUES - 2013

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 7 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 7 adopted and the remainder of the Report filed.

Board of Trustees Report 7 recommends no changes to our AMA membership dues levels for 2013. The Report further notes that our AMA last raised its dues in 1994.

Regular Members	\$420
Physicians in Their Second Year of Practice	\$315
Physicians in Military Service	\$280
Physicians in Their First Year of Practice	\$210
Semi-Retired Physicians	\$210
Fully Retired Physicians	\$84
Physicians in Residency Training	\$45
Medical Students	\$20

Your Reference Committee received no online opposition to this report and no on-site testimony beyond the introduction of this item; therefore, your Reference Committee accepts our AMA Board of Trustees' decision to maintain the long-standing trend of not increasing the membership dues levels.

(2) BOARD OF TRUSTEES REPORT 11 - DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 11 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 11 adopted and the remainder of the Report filed.

Board of Trustees Report 11 recommends that the current ballot system remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and a national medical specialty society.

Your Reference Committee received limited online and on-site testimony about this complex issue. The mechanism for recording specialty society designation for representation in the House of Delegates affects states and specialty societies and has been debated in the past by the House of Delegates and the Specialty and Service Societies (SSS). Your Reference Committee believes that the Board of Trustees and the SSS should be allowed to continue the paper ballot system while examining other options for recording specialty society designation.

Your Reference Committee also asks that any recommendations ultimately made by the Board of Trustees and the SSS include clear instructions for members regarding the process for designating their specialty society preference.

(3) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 2 - RECONCILIATION PROCESS FOR AMA POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 adopted and the remainder of the Report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 proposes recommendations to strengthen the existing policy sunset and consolidation processes. This report focuses on reconciling disparate policies particularly those that are adopted from this point forward.

Your Reference Committee received no online or on-site objections to this report and expresses its appreciation once again to the Council on Constitution and Bylaws and the Council on Long Range Planning and Development for their efforts to ensure that our AMA's Policy Database does not include duplicative, conflicting, or inconsistent policies.

(4) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 4 - JOINT COUNCIL SUNSET REVIEW OF 2002 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 4 adopted and the remainder of the Report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 4 presents a review of our AMA House of Delegates directives adopted in 2002, with a goal of sunsetting those that have been accomplished or are obsolete. Directives that are sunset will be retained in our AMA's historical archives.

Your Reference Committee received limited online testimony on this report. Your Reference Committee received significant on-site testimony complimenting the collaboration among our AMA councils to develop these recommendations. Your Reference Committee also received testimony asking that specific policies being recommended for sunset be retained, specifically D-60.992, Bullying Behaviors Among Children and Adolescents; D-435.993, No-Fault Malpractice System, D-390.988, Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error; D-350.997 Racial and Ethnic

Disparities in Health Care; and D-230.992 Hospital Medical Staff Privileges; and D-165.978 Advocating Health Insurance Tax Credits.

Your Reference Committee examined closely existing policies and concurred with CCB/CLRPD in their original recommendations. As an example, while testimony passionately supported retention of D-60.992, Reference Committee E is supporting the Council on Science and Public Health's recommendation to retain Policy H-60.943 Bullying Behaviors Among Children and Adolescents as still relevant, which is a much more comprehensive statement of policy. With respect to D-230.992, Hospital Medical Staff Privileges, sunseting this directive does not preclude our AMA from continuing to communicate AMA policies to the American Hospital Association; in fact, that action is integral to the work of the Organized Medical Staff Section and our AMA's advocacy efforts.

Your Reference Committee also supports the councils' recommendations with respect to D-435.993, No-Fault Malpractice System; D-390.988, Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error; D-350.997, Racial and Ethnic Disparities in Health Care; and D-165.978, Advocating Health Insurance Tax Credits. In doing so, your Reference Committee emphasizes that there is a difference between the "H" policies, and the "D" directives. Directives are typically needed for a very short period of time (with a maximum horizon of 10 years); they either are accomplished within that period of time or become so intertwined with ongoing AMA activities that the directive is no longer necessary.

(5) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - MODIFICATIONS TO EXISTING AMA POLICIES TO BETTER GUIDE AMA POLICY DEVELOPMENT, CONSOLIDATION, SUNSET AND IMPLEMENTATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1, Recommendation 3 be amended on page 4, lines 15-18 to reinstate language originally contained in G-605.070 to read as follows:

...Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1, Recommendations 6, 7 and 8 be amended to read as: Recommendations 4, 5 and 6.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1, Recommendation 4 be amended on page 4, lines 47-48 to reinstate language originally contained in G-600.005 to read as follows:

Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 adopted as amended and the remainder of the Report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 presents recommendations for amending and consolidating existing House of Delegates policies. The purposes for these changes to existing policies are multifactorial:

- 1) editorial changes to clarify existing policies;
- 2) deletion of various policy statements that have been accomplished or embodied elsewhere;
- 3) expansion of the policies where warranted; and
- 4) consolidation of several similar policies.

The Councils believe that the proposed changes will greatly aid in sunseting policies that are no longer relevant or which were accomplished, as well as operationalize how policy amendments and consolidation can be accomplished.

Your Reference Committee received no online objections to this report and expresses its appreciation to the Council on Constitution and Bylaws and the Council on Long Range Planning and Development for their thorough and thoughtful recommendations, which provide tremendous guidance to our AMA House of Delegates and further clarity to our AMA Policy Database.

Your Reference Committee received on-site testimony from the councils noting that revised language for Recommendation 3 (on page 3, line 5) in CCB/CLRPD 1-A-12 had been submitted and distributed in the Sunday tote to make it clear in the recommended policy consolidation statement that "Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House." The councils in testimony proposed the reinstatement of some language on page 4, lines 15-18 that was inadvertently deleted.

Your Reference Committee also received specific recommendations during testimony for changes to two policies, specifically G-600.120, Implementation of House Policy; and G-600.061, Guidelines for Drafting a Resolution or Report. However, given that the councils stressed that their intent was not to change policy, but rather to eliminate matters more appropriately covered elsewhere, your Reference Committee did not recommend those changes be incorporated into CCB/CLRPD 1-A-12.

- (6) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 3 - JOINT COUNCIL REVIEW OF ALL HOUSE GOVERNANCE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 on Policy G-605.050, Annual Reporting Responsibilities of our AMA Board of Trustees, be amended to read as follows:

- 1) Editorially update Recommendation 45 for accuracy: AMA ~~W~~web-site;
- 2) Delete Recommendation 3, as it has been superseded by G-600.005;
- 3) Retain balance of policy as it is still relevant.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 with respect to Policy G-615.100, Organized Medical Staff Section (OMSS), be amended to retain the parenthetical phrase "(according to their bylaws)" in Recommendation 4, to read as follows:

- (2) Our AMA will continue to...b) encourage them to appoint a representative (by election or selection, according to their by-laws) to attend our AMA-OMSS meetings and then communicate information back to members of their medical staff.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Policies D-600.975, AMA Assembly Meeting Space; G-630.140, Lodging and Accommodations; G-630.130 Discrimination; and G-630.141 Future AMA Meetings in Smoke-Free Facilities/Hotels be referred for consolidation into a single comprehensive policy.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the report be adopted as amended, and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 adopted as amended, with HOD Policies D-600.975, G-630.140, G-630.130, and G-630.141 referred; and the remainder of the report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 presents recommendations on the disposition of our AMA governance policies and directives emphasizing those that should be sunset, amended and/or consolidated, with an overarching goal of making the policy database more accurate, concise, and streamlined.

Your Reference Committee received no online objections to this report and continues to express its appreciation to the Council on Constitution and Bylaws and the Council on Long Range Planning and Development for making our AMA Policy Database more accurate, concise, and streamlined.

During on-site testimony, the councils asked that their recommendation with respect to G-605.050 be modified in two ways: modify Recommendation 1 to read, "Update Recommendation 4 (rather than Recommendation 5); and 2) to Delete Recommendation #3, as more recent policy G-600.005 states that the "required information on the budget will be provided to the HOD at a time and format more relevant to our AMA budget process." Your Reference Committee also noted that the Sunday tote included an updated recommendation for D-640.994, AMA Government Relations Advocacy Fellowship.

All other testimony received during the Reference Committee hearing was largely complimentary of what was recognized as a gargantuan effort. Some concern, however, was noted about editorial changes to G-630.040, Principles on Corporate Relationships. Your Reference Committee also received testimony asking that several policies be retained rather than sunset: D-630.972, Progress Report on Resolution 606-A-06, Improving Collection of AMA Race/Ethnicity Data; D-630.973, Improving Collection of AMA Race/Ethnicity Data; and D-165.978 Advocating Health Insurance Tax Credits.

Your Reference Committee discussed the additional modifications proposed during the on-site testimony and supplemented by written commentary to G-630.040, Principles on Corporate Relations, but supports the councils' recommendations for amendment. Similarly, your Reference Committee supports the councils' recommendation action on D-630.972, D-630.973, D-165.978.

- (7) RESOLUTION 612 - AMA MEETING SCHEDULE
RESOLUTION 615 – SELECTION OF AMA INTERIM MEETING LOCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 612 be adopted in lieu of Resolution 615.

HOD ACTION: Substitute Resolution 612 adopted as amended in lieu of Resolution 615.

RESOLVED, That our AMA convene as a pilot a combined interim policy-making meeting and National Advocacy Conference (Directive to Take Action); and be it further

RESOLVED, That the combined meetings be held at a location in the Washington, DC metropolitan area and at an appropriate time to avoid incurring contractual penalties (Directive to Take Action); and be it further

RESOLVED, That the pilot take place within a reasonable timeframe, and with adequate notice to the members of the House of Delegates (Directive to Take Action); and be it further

~~RESOLVED, That our AMA sections be afforded an opportunity to convene a stand-alone meeting during the year in which the combined pilot meeting is scheduled (Directive to Take Action);~~

RESOLVED, That our AMA sections be afforded the opportunity to meet immediately prior to and in close proximity to the meetings of the AMA House of Delegates (Directive to Take Action).

Resolution 612 calls upon our AMA to:

- continue its pursuit of operational efficiencies of the House of Delegates (HOD) to incorporate the “open to all AMA members” electronic virtual reference committee hearings so that the majority of testimony and opinion is captured for reference committee deliberation and publication prior to the opening session of all meetings of the HOD;
- convene Annual Meeting reference committees hearings on Saturday afternoon with the speech, award, and ceremonial events traditionally scheduled for opening session to occur on Sunday morning, thus providing for the preparation of final reference committee reports in time for the house to begin its deliberations by Sunday noon;

- adjust the Annual Meeting schedule to allow attendees to gain an extra day in their practice by adjourning the meeting at a specific time on Tuesday or earlier, but definitely in time for return travel home that day;
- combine and convene the National Advocacy Conference and the Interim Meeting in late winter or early spring in Washington, DC, when Congress is in session, which would allow: (1) the HOD to deliberate AMA policy on advocacy issues; (2) important guests to address, debate, and inform meeting attendees on current federal issues; and (3) attendees to optimally schedule meetings with every member of Congress and important representatives of the Administration for maximum effect;
- study and make recommendations to the House of Delegates at the 2012 Interim Meeting on the logistics of inviting all American physicians, spouses, patients, and leaders, and members of state and specialty societies to participate in the newly reformatted annual advocacy meeting in Washington, DC;
- study and make recommendation to the House of Delegates at the 2012 Interim Meeting on the feasibility of moving the Annual Meeting to a time later in the calendar year to balance the annual needs of the HOD to meet and deliberate AMA policy during the Association's two cornerstone events; and
- commence these meeting format and schedule changes when current facility commitments have been completed.

Resolution 615 calls upon our AMA to modify current Policy G-600.130 to state that the Interim Meeting be held in Hawaii every 6-8 years, and that it be held in Washington, DC every 4-6 years.

Your Reference Committee received mixed testimony in response to Resolution 612, with no obvious consensus. Prior testimony and current testimony reflect that there are three positions regarding the Interim Meeting of our AMA House of Delegates: (1) maintain status quo; (2) discontinue the Interim Meeting; and (3) combine the Interim Meeting with the National Advocacy Conference. Your Reference Committee believes that the two-thirds who are seeking an overall change will continue this debate, but will not achieve majority agreement without tangible and tested evidence of the impact of any specific recommendation.

Concerning Resolution 615, your Reference Committee believes that the previously described pilot should be convened and evaluated prior to considering any further restrictions on the scheduling of policy-making meetings.

(8) RESOLUTION 609 - HEALERS AND HEROES PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 609 be referred.

HOD ACTION: Resolution 609 referred for decision.

Resolution 609 calls upon our AMA to institute a national program based on the Healers and Heroes Program, or Vet2Vet program that will confidentially connect military personnel returning from deployment with physician volunteers who have previous military service to provide counsel for their healthcare needs.

Your Reference Committee thanks the New Jersey delegation for introducing this resolution and for raising our awareness of the unique problems military veterans have in seeking medical care once they are discharged from active duty.

Testimony on this resolution was mixed and included references to similar veteran advisory programs in other states. Your Reference Committee also heard testimony that our AMA should strive to clearly understand what services returning veterans require before it commits to instituting a similar program. Therefore, your Reference Committee believes more information needs to be obtained before a decision can be made as to whether our AMA should institute a veterans advisory program.

(9) RESOLUTION 603 - AMA - MY MEDICATIONS APP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 603 not be adopted.

HOD ACTION: Resolution 603 not adopted.

With the intent of promoting our AMA's mission, vision, and values, and casting a more positive light on our AMA brand, Resolution 603 calls upon the Board of Trustees to consider making the "My Medications" application, which enables patients to store, carry, and share their critical medical information on their iPhone, iPad, and iPod Touch, available at no charge to all patients who utilize the services of an AMA member physician.

Your Reference Committee received mixed online and on-site testimony suggesting that there would likely be value for our AMA brand, but that there would be hurdles associated with implementation should Resolution 603 be accepted by our AMA House of Delegates. Additionally, testimony indicated that the "My Medications App" has serious drawbacks in its design and utility: it does not seamlessly transfer information to electronic health records, it is time-limited, it is not supported in an emergency situation, and there is no Android version of the application.

Your Reference Committee discussed the fact that our AMA would likely incur additional cost to modify the existing application to either verify AMA membership and/or allow patients to indicate if their physician is an AMA member in order to allow a free download. While verifying a physician membership status would use our AMA Physician Masterfile, our AMA would most likely have to rely on the honor system with patients (i.e., any patient claiming that their physician was an AMA member would be allowed to download the application for free). Furthermore, your Reference Committee believes that the \$.99 minimal charge is not a deterrent to users; whereas, free applications are frequently available only with embedded advertisements, which may be a deterrent to potential users who assume our AMA application includes such advertisements. Finally, AMA policy directs that it is not within the purview of our AMA House of Delegates to engage in the development and marketing of business products.

(10) RESOLUTION 605 - USE OF VIRTUAL REFERENCE COMMITTEES
BY THE AMERICAN MEDICAL ASSOCIATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 605 not be adopted.

HOD ACTION: Resolution 605 not adopted.

Resolution 605 calls upon our AMA to direct a review of the issues surrounding the use of "virtual reference committees" and to report its review at the 2012 Interim Meeting.

Your Reference Committee received online testimony supporting the use of virtual reference committees. Research indicated that the use of virtual reference committees does not violate AMA Bylaws, and this fact was confirmed by on-site testimony provided by the Council on Constitution and Bylaws.

Furthermore, Policy G-600.005, *Improving Processes of the House of Delegates* states, "Virtual reference committees will be pilot tested in the House of Delegates."

The virtual reference committee process is currently being pilot tested. The 2012 Annual Meeting of our AMA House of Delegates is only the second meeting at which the process is being used by all reference committees. The process is subject to ongoing review and change by the Speakers, who have indicated that they continue to look for ways to improve and refine the use of virtual reference committees. It is the intent of the Speakers to bring back recommendations to the House of Delegates. At this time, the use of virtual reference committees is evolving.

On-site testimony indicated there are substantive concerns with what is currently referred to as the preliminary reports of reference committees, and there is no formal mechanism in place with which to provide the desired feedback to the Speakers. For this reason, your Reference Committee believes the intent of Resolution 605 can be best achieved through the establishment of an online discussion forum, which will provide for an ongoing and interactive dialogue while the pilot test is underway.

(11) RESOLUTION 607 - AMA ONLINE PHYSICIAN PLATFORM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 607 not be adopted.

HOD ACTION: Resolution 607 not adopted.

Resolution 607 calls upon our AMA to offer more than one laboratory information system/electronic health record solution as part of its online physician platform.

Your Reference Committee heard limited testimony on Resolution 607. Testimony pointed out that our AMA and AT&T have formed a strategic alliance in which AT&T will own and operate the combined AMAGINE and AT&T physician online platforms as AT&T Healthcare Community Online. The combined platform does not have exclusivity with Quest or any other laboratory. A physician may use any laboratory he or she chooses.

Your Reference Committee also received amended language that was determined to be tangential to Resolution 607 and could instead be introduced to the House as a separate Resolution at an appropriate time.

(12) RESOLUTION 610 - PARTICIPATION IN CPT PROCESS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 610 not be adopted.

HOD ACTION: Resolution 610 not adopted.

Resolution 610 calls upon our AMA to Board of Trustees to:

- review the CPT Editorial Panel process, including the implications of industry involvement, and make recommendations to the Panel to assure the integrity of the process;
- consider encouraging our AMA CPT Editorial Panel to minimize any inappropriate influence on the CPT Editorial Process;

- consider recommending to the CPT Editorial Panel inclusion in the introduction to the CPT code book a clarification of the role of specialty society CPT Advisors in the CPT process (i.e., “All proposed changes to the CPT code set will be considered by the CPT Editorial Panel, in consultation with medical specialty societies, as represented by the Health Care Professionals Advisory Committee (“HCPAC”), and other interested parties.”); and
- consider recommending to the CPT Editorial Panel that it strive to have the support of at least one medical specialty society before implementing a code change and that our AMA Board of Trustees urge medical societies and other interested parties to avail themselves of the process for seeking reconsideration of an action taken by the CPT Editorial Panel where there is concern that the Panel did not properly take into account specialty society input regarding a proposed new or revised CPT code.

Your Reference Committee heard testimony that generally did not support this Resolution. The CPT editorial process is subject to oversight by the Board of Trustees, and testimony reflected serious concerns that any perceived or actual involvement of the House of Delegates in the CPT editorial process could jeopardize the independence of the CPT Editorial Panel. There was testimony that the CPT Editorial Panel has sufficient policy and procedures in place to ensure fairness, integrity, and independence in its deliberation and decision-making, and there is no need to interfere with its established processes.

In addition, interference with the CPT editorial process could strengthen the argument of those who seek to take the CPT process away from physicians. It is vitally important that physicians maintain their leadership role in defining medical services and procedures.

(13) RESOLUTION 611 - UNIFORMITY OF CPT DISCLOSURE AND CONFIDENTIALITY POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 611 not be adopted.

HOD ACTION: Resolution 611 not adopted.

Resolution 611 calls upon our AMA to encourage the CPT Editorial Panel to implement and enforce a uniform disclosure and confidentiality policy for all participants in the CPT process.

Your Reference Committee heard testimony that did not support this Resolution. The Chair of the CPT Editorial Panel indicated that a uniform confidentiality policy is currently in place and is consistently enforced by the CPT Editorial Panel. As with Resolution 610, further testimony reflected that the House of Delegates should not be involved in the operations of the CPT Editorial Panel.

(14) RESOLUTION 613 - TRIAGE OF AMA RESOLUTIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 613 not be adopted.

HOD ACTION: Resolution 613 not adopted.

Resolution 613 calls upon our AMA to develop a mechanism encouraging consideration of resolutions that align with our AMA mission. Additionally, Resolution 613 calls upon our AMA to establish a method of measuring the fiscal impact of a resolution on patients and physicians.

Your Reference Committee heard limited testimony on this Resolution. However, the democratic process of our AMA House of Delegates depends on clear communication and transparency to establish trust and to ensure that all voices are heard. In addition, your Reference Committee believes that Resolution 613 is contrary to item 3 in Policy G-600.060, "Introducing Business to the AMA House", which states:

- 3) Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates, especially during its efforts to streamline the business of our AMA.

(15) RESOLUTION 614 - AMA LEADERSHIP TRANSPARENCY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 614 not be adopted.

HOD ACTION: Resolution 614 not adopted.

Resolution 614 calls upon our AMA Board of Trustees, councils, and committees to make minutes and decision-making votes available to the general membership on a regular basis except in instances where legal constraints exist.

Your Reference Committee heard mixed testimony on this Resolution. At the 2010 Annual Meeting, the House of Delegates adopted Policy D-605.986, "Recording and Reporting Trustees' Votes," which states:

Our Speakers will convene a task force of our AMA House of Delegates, with representation from our Board of Trustees, to examine and report back at the 2011 Annual Meeting on the issue of recording and reporting votes of our Board of Trustees.

The Report of the Task Force on Recording and Reporting Trustees' Votes was presented at the 2011 Annual Meeting and recommended that the current practice of not recording and reporting Trustees' votes remain in place because the ability of the Board of Trustees to present a unified position would be threatened and effectiveness diminished were this practice to be instated. At that time, testimony presented to Reference Committee F also reflected that the ability of our AMA Board of Trustees to maintain unity in its position is imperative to its success on behalf of all physicians.

Current testimony reflected that AMA members in good standing are encouraged to seek permission to attend Board of Trustees meetings to observe the deliberations and decision-making processes of the Board. This is supported by Policy G-605.080, "Board Meetings," which states that:

- 1) The House holds the Board accountable for the proper oversight of our AMA, but not through (a) the recording and publication of individual votes on matters before the Board, or (b) open meetings, because neither will enhance the Board's deliberations and may hinder the Board's decision-making process.
- 2) Any AMA member in good standing shall be allowed full access to AMA Board of Trustees meetings upon advance notification to the Chair of the Board unless issues of personnel or sensitive nature require an executive session.

(16) RESOLUTION 601 - AMA TRUTH SQUAD

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-445.995 be reaffirmed in lieu of Resolution 601.

HOD ACTION: HOD Policy H-445.995 reaffirmed in lieu of Resolution 601.

Resolution 601 calls upon our AMA Communications Department to form a "Truth Squad" whose purpose would be to address any negative publicity, comments, or statements that may be deemed derogatory and/or anti-physician.

Your Reference Committee received limited online testimony along with significant on-site opposition to the title of this resolution. Additionally, your Reference Committee received both online and on-site testimony suggesting it is the ongoing charge of our AMA Communications Department to remain knowledgeable about media coverage concerning our profession and medical issues, and to correct erroneous information wherever and whenever possible. Your Reference Committee recognizes that not every effort to promulgate the truth will garner as broad attention as the sometimes more glamorous misinformation.

A member of the Board of Trustees reported that our AMA's media relations team strives to position the organization and the medical profession in a positive light through proactive outreach to reporters, bloggers, physicians, and the public on a wide variety of topics. In addition to significant media placement across the country on key AMA issues, the team also works to combat negative or inaccurate articles, opinion pieces and other material in a timely manner. In 2011, our AMA media relations team placed 34 letters to the editor in news publications across the nation in response to articles or columns. They also posted 158 comments on blogs or online articles to correct inaccuracies and provide positive, factual information about our AMA and physicians. In addition, the team works regularly with reporters to stop false or misleading information before it is published and to provide positive physician voices and proven data that appear in thousands of articles each year. With more than 16,260 media placements in 2011 on topics ranging from public health and medical education to the practice of medicine and health care policy, our AMA media relations team makes sure a strong physician voice is heard through columns and letters to the editor, interviews with physician leaders, responses to incorrect information in print or online, and the distribution of factual reports and information.

Your Reference Committee further believes that responsibility for ensuring media accuracy on all medical matters is a Federation-wide concern and therefore recommends reaffirmation of Policy H-445.995, *Responses to News Reports and Articles*, which reads as follows:

Our AMA encourages the public relations committees of all county, state and national medical societies to initiate positive programs with the media and to make timely responses to misleading and inaccurate media releases giving the general public a more accurate and balanced perspective of the medical profession and medical issues. (Res. 10, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed A-07)

(17) **RESOLUTION 604 - AMA PRIORITIES AND PRIVATE GROUP PRACTICE**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-405.988 be reaffirmed in lieu of Resolution 604.

HOD ACTION: Resolution 604 adopted.

RESOLVED, That our American Medical Association utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care. (Directive to Take Action)

**Change in Title to read as follows:
AMA PRIORITIES AND PRIVATE, SOLO, AND SMALL GROUP PRACTICE**

Resolution 604 call upon our AMA to utilize its resources to protect and support the continued existence of solo and small group medical practices, and to protect and support the ability of these practices to provide quality care.

Your Reference Committee received online and on-site testimony that was generally supportive of the intent of this resolution. Among those providing testimony was the recently formed Private Practice Physicians Caucus, which your Reference Committee wishes to support by encouraging caucus meeting attendance and listserv participation.

Your Reference Committee believes that current Policy D-405.988, *The Preservation of the Private Practice of Medicine* is a more comprehensive and supportive position favoring private practice physicians. For this reason, your Reference Committee favors reaffirmation of the existing policy, which reads as follows:

Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (3) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; and (4) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine. (Res. 224, I-10)

(18) RESOLUTION 608 - VIOLENCE OR INTIMIDATION DIRECTED TOWARD OR BY MEDICAL PROFESSIONALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-515.982 be reaffirmed in lieu of Resolution 608.

HOD ACTION: HOD Policy H-515.982 reaffirmed in lieu of Resolution 608.

Resolution 608 calls upon our AMA to condemn any form of violence or intimidation directed toward or by medical professionals.

AMA has existing policy condemning violence either perpetrated by physicians or directed toward physicians. Foremost among these is E-1.001, "Principles of Medical Ethics" (AMA Policy Database), and H-515.982, "Violence Acts Against Physicians" (AMA Policy Database).

H-515.982 VIOLENT ACTS AGAINST PHYSICIANS

Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; and (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity.

(Res. 605, A-92; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09)

Testimony indicated that our AMA also supports policies of the World Medical Association (WMA) concerning violence and physician behavior. The Declaration of Geneva, The Declaration of Tokyo, and the WMA statement on Regulation in Times of Armed Conflict all speak out against violence and any activity that would cause harm to a patient.

Testimony further indicated that our AMA has acted upon these policies frequently in the past year as physicians have been persecuted for caring for victims of government-sponsored violence in Bahrain and Syria. Our AMA sent letters to the highest levels of government advocating for the rights of physicians to practice medicine without interference and violent retribution in January and May of 2012. The most recent was co-signing (with the WMA) a letter to President Assad in Syria through the auspices of Physicians for Human Rights (PHR). The PHR website also allows individuals to sign on. Our AMA will continue to focus on physician human rights and will continue to speak out on its own and with international partners to uphold existing policy and the highest standard of ethical behavior.

(19) BOARD OF TRUSTEES REPORT 1 - AUDITOR'S REPORT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

Board of Trustees Report 1 serves to introduce our Association's 2010 and 2011 Consolidated Financial Statements along with an Independent Auditor's report, which are featured in a separate booklet, titled "2011 Annual Report" that was distributed with the Handbook materials.

Your Reference Committee received an informative presentation of our AMA's financials that reflected 2011 operating income was \$24.7 million, marking the 12th consecutive year our AMA has achieved positive operating results. Additionally, it was announced that AMA membership at year-end had increased for the first time in years. Finally, the "AMA Equation" was introduced, which is a metaphor for five core elements of our AMA: the House of Delegates; individual members; practice management tools; research and education; and advocacy.

Your Reference Committee would like to commend our AMA Board of Trustees and staff for their efforts to maintain our AMA's strong financial position despite continuing economic challenges and for the positive results that are being achieved in our AMA membership.

Reference Committee G (Medical practice)

- (1) BOARD OF TRUSTEES REPORT 9 - ELECTRONIC HEALTH RECORD
"LEMON LAW"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation contained in Board of Trustees Report 9 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 9 adopted and the remainder of the report filed.

Board of Trustees Report 9 recommends that the AMA pursue possibilities, consistent with its strategic direction and existing guidelines for working with third parties, to develop tools, accessible to all AMA members, which can help physicians in the selection and evaluation of electronic health records.

There was limited yet generally supportive testimony on Board of Trustees Report 9. A member of the Board of Trustees introduced the report and acknowledged the difficulties and liabilities encountered by organizations working to rate electronic health records. Additional testimony referenced AMA policy on open source code medical records. Your Reference Committee notes that AMA advocacy efforts in that arena have focused on usability criteria for electronic health records, and importantly, there are open-source electronic health records now available. Your Reference Committee believes that the tools called for in this report to assist physicians in the selection and evaluation of electronic health records would be of incredible value to AMA members. Therefore, your Reference Committee recommends adoption of Board of Trustees Report 9 as written.

- (2) COUNCIL ON MEDICAL SERVICE REPORT 6 - SMALL BUSINESSES
AND HEALTH REFORM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations contained in Council on Medical Service Report 6 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 6 adopted and the remainder of the report filed.

Council on Medical Service Report 6 provides a summary of legislative activity, highlights the potential impact of the ACA on the decision of small businesses to self-insure, outlines how self-insuring impacts physicians and patients, and summarizes relevant AMA policy.

Your Reference Committee heard limited but generally supportive testimony on Council on Medical Service Report 6. A member of the Council on Medical Service introduced the report, and noted the concern of the Council with respect to the impact of small businesses self-insuring at a much greater rate. A speaker raised concerns regarding the impact of the sixth recommendation on the future availability of health insurance offered to enrollees of self-insured plans. A member of the Council on Medical Service clarified that the sixth recommendation would ensure the adequacy and financial security of health insurance coverage offered to employees of self-insured plans, and limit the availability of "sham" health insurance coverage offered to small businesses who choose to self-insure and their employees, which is consistent with existing AMA policy opposed to "sham" health insurance coverage. Your Reference Committee believes that the recommendations of the report provide a good framework for the AMA to respond to issues related to the health insurance coverage of employees of small businesses, and recommends its adoption.

(3) RESOLUTION 703 - SUPPORT OF MULTILINGUAL ASSESSMENT TOOLS FOR MEDICAL PROFESSIONALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 703 be adopted.

HOD ACTION: Resolution 703 adopted.

Resolution 703 asks that our AMA encourage the publication and validation of standard patient assessment tools in multiple languages.

Testimony on Resolution 703 was limited to the sponsor. Your Reference Committee notes that the resolution is consistent with several policies that promote the consistency and equity of care for all persons and agrees with testimony that encouraging such efforts can be accomplished at a low cost. Therefore, your Reference Committee recommends that Resolution 703 be adopted.

(4) RESOLUTION 713 - TRANSPARENCY IN RECRUITING AND MARKETING TECHNIQUES FOR YOUNG PHYSICIANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 713 be adopted.

HOD ACTION: Resolution 713 adopted.

Resolution 713 asks that our AMA explore strategies to increase transparency in marketing techniques used to recruit physicians who are finishing their residency or fellowship to ensure that hospitals, clinics, or health plans are not using deceptive or anti-competitive recruiting techniques without fully disclosing all components of any contract with the physician being recruited; and work through its councils and sections to develop resources to assist physicians in training in career decision-making that provides them the full range of information concerning various practice models, including private practice.

Your Reference Committee received mixed testimony on Resolution 713. Although testimony supported the intent of the resolution, there was concern that the resolution did not go far enough to identify which techniques are deceptive or lack transparency. Those in support of Resolution 713 thanked the author for highlighting this important matter and commended the Organized Medical Staff Section (OMSS) for its ability to assist new physicians in their employment decisions. Your Reference Committee concurs with supportive testimony, and recognizes that OMSS is likely to have keen insight on how to address the concerns raised in this resolution. Therefore your Reference Committee recommends that Resolution 713 be adopted.

(5) RESOLUTION 719 - THE IMPORTANCE OF LOCAL CONTROL OF HOSPITALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 719 be adopted.

HOD ACTION: Resolution 719 adopted.

Resolution 719 asks that our AMA establish policy and advocate for local governing boards to continue to exist for individual hospitals within multi-hospital systems to ensure that community needs, the needs of local medical staff and patient care needs are met within those communities whenever possible.

Your Reference Committee heard highly supportive testimony on this resolution. Your Reference Committee notes that the AMA organized a sign-on letter in response to the proposed rule concerning the reform of the Hospital and Critical Access Hospital Conditions of Participation that addressed the issue outlined in Resolution 719, which can be found at <http://www.ama-assn.org/resources/doc/omss/temp/cop-comments.pdf>. The AMA has continued its advocacy on this issue since the final rule was published. Accordingly, your Reference Committee recommends that Resolution 719 be adopted.

(6) RESOLUTION 726 - MEDICAL EXAMINER PATIENT POSTMORTEM:
CAUSE OF DEATH TRANSPARENCY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that that Resolution 726 be adopted.

HOD ACTION: Resolution 726 adopted.

Resolution 726 asks that our AMA convene a study group to examine strategies to implement a postmortem process or standard for ongoing communication between the medical examiner, physicians, health care providers, and family members; and develop guidelines for hospital processes for communication between medical examiners, clinicians, families, medical staffs, and other key stakeholders to establish a postmortem management methodology that includes timely communication between all parties.

Testimony on Resolution 726 was mixed. Speakers who testified in support of the resolution believed that its suggested multi-pronged approach would enhance guidance on this issue. Additional speakers supported the intent of the resolution, but supported referral to allow interested physician groups to collaborate and strengthen the request. Others cautioned against studies that could potentially pose an unfunded mandate for physicians to provide postmortem services. However, the sponsor noted that families are willing to pay for autopsies and payment for these services should not preclude a study that would help guide physicians. Your Reference Committee notes that existing AMA policy does not address pitfalls related to communication between physicians and families concerning autopsies. Your Reference Committee believes that guidance on this issue would be useful to physicians and recommends that Resolution 726 be adopted.

(7) BOARD OF TRUSTEES REPORT 14 - BEERS OR SIMILAR CRITERIA
AND THIRD PARTY PAYER COMPLIANCE ACTIVITIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Board of Trustees Report 14 be amended by insertion and deletion to read as follows:

2. That our AMA adopt policy clarifying that while it is appropriate for the Beers Criteria and appropriate use guidelines to be incorporated in quality measures, such measures should not be applied in a punitive or onerous manner to physicians and must recognize the multitude of circumstances where deviation from the quality measure may be appropriate, and inform health insurers and other payers of this policy.
(New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations contained in Board of Trustees Report 14 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 14 adopted as amended and the remainder of the report filed.

Board of Trustees Report 14 recommends that the AMA adopt policy discouraging health insurers, benefit managers, and other payers from using the Beers Criteria and other similar lists to determine coverage and/or reimbursement; and adopt policy clarifying that while it is appropriate for the Beers Criteria to be incorporated in quality measures, such measures should not be applied in a punitive or onerous manner to physicians and must recognize the multitude of circumstances where deviation from the quality measure may be appropriate, and inform health insurers and other payers of this policy.

Your Reference Committee heard generally supportive testimony on Board of Trustees Report 14. A member of the Board of Trustees introduced the report, noting the use of Beers criteria or similar criteria in the arenas of coverage decisions and quality measures. A speaker noted that appropriate use guidelines are also being used by health insurers, benefit managers, and other payers in the arenas of coverage, reimbursement and quality, and offered an amendment to broaden the scope of the second recommendation of the report to also include the utilization of appropriate use guidelines. Your Reference Committee agrees that such additions would strengthen the recommendations of the report. Your Reference Committee believes that the recommendations of the report as amended will serve as a strong foundation upon which the AMA can advocate on the state and federal levels, as well as in the private sector, which addresses the intent of another amendment offered in testimony. As such, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended.

- (8) BOARD OF TRUSTEES REPORT 17 - HOSPITAL ELECTRONIC MEDICAL RECORDS AND COMPUTERIZED PHYSICIAN ORDER ENTRY PROBLEM
RESOLUTION 721 - COMPREHENSIVE ANALYSIS OF POTENTIAL ERRORS FACILITATED BY THE IMPLEMENTATION OF COMPUTERIZED PHYSICIAN ORDER ENTRY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation contained in Board of Trustees Report 17 be amended by insertion and deletion to read as follows (Reference Committee changes shown as double strikethrough and double underline):

The Board of Trustees recommends that, in lieu of Resolution 711-A-11, our AMA amend Policy D-478.995 by addition of a new clause 2(D) to read as follows, and that the remainder of the report be filed:

D-478.995 National Health Information Technology

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of ~~EMR~~ electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and

health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on ~~EMR~~ EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for more research on ~~the electronic health record (EHR), and computerized physician order entry (CPOE) and clinical decision support systems~~ and vendor accountability for the efficacy, effectiveness, and safety of these systems.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation contained in Board of Trustees Report 17 be adopted as amended in lieu of Resolution 721 and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 17 adopted as amended in lieu of Resolution 721 and the remainder of the report filed.

Board of Trustees Report 17 recommends that the AMA advocate for more research on the electronic health record (EHR) and computerized physician order entry (CPOE) systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

Resolution 721 asks that our AMA conduct a comprehensive study of the potential increase in errors incurred by computerized physician order entry (CPOE) adoption in hospitals and ambulatory clinics and suggest suitable solutions or alternatives such as CPOE standardization within different electronic health record systems.

There was supportive testimony on Board of Trustees Report 17. A member of the Board of Trustees testified that additional policy on EHR and CPOE vendor accountability would strengthen AMA policy addressing EHRs. An amendment was proposed in support of broadening the scope of Policy D-478.995, which Board of Trustees Report 17 recommends amending, to include advocating for more research on clinical decision support systems.

Testimony on Resolution 721 was limited and mixed. There was testimony that questioned whether the AMA was the appropriate entity to conduct the study called for in the resolution, and whether such a study was necessary. However, your Reference Committee is cognizant of the spirit and intent of Resolution 721, and believes that the additional amendments proposed to the recommendation of Board of Trustees Report 17 fulfills the intent of Resolution 721. Also, your Reference Committee made amendments to use "electronic health records (EHRs)" consistently throughout Policy D-478.995. Accordingly, your Reference Committee recommends that the recommendation in Board of Trustees Report 14 be adopted as amended in lieu of Resolution 721.

(9) COUNCIL ON MEDICAL SERVICE REPORT 3 - MEDICAID PATIENT-CENTERED MEDICAL HOME MODELS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 3 be amended by insertion to read as follows:

That our American Medical Association (AMA) recognize that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by

improving access, quality and outcomes while reducing costs. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Council on Medical Service Report 3 be amended by insertion to read as follows:

That our AMA work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that recommendations contained in Council on Medical Service Report 3 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 3 outlines relevant AMA policy, highlights the Community Care of North Carolina patient-centered medical home (PCMH), and provides examples of other state Medicaid PCMH models, including a pregnancy medical home model.

Testimony for Council on Medical Service Report 3 was highly supportive and applauded the Council for its well-prepared report. Some speakers testified that the second recommendation of the report should be amended by insertion to include language in support of including pregnancy medical home models. Others testified that the Principles of the Patient-Centered Medical Home (Policy H-160.919) broadly describe the desired attributes of patient-centered home models in a way that is suitable for all physician approaches. Additional testimony focused on the merits of physician leadership beyond specialty concerns. Your Reference Committee agrees that physician leadership of medical home models is a core concept that should be underscored. Testimony also questioned whether the AMA should support the savings data presented in the report. Your Reference Committee acknowledges that medical charges do not equal health care costs. However, your Reference Committee continues to believe that physicians should be encouraged to seek models that provide better health, better care and reduced health care costs. Accordingly, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended.

(10) COUNCIL ON MEDICAL SERVICE REPORT 4 - CMS SUNSET
REVIEW OF 2002 HOUSE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be amended by insertion to read as follows:

That our American Medical Association policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of Policies H-180.954, H-225.964, H-225.973, H-285.979 and H-335.964, which should be retained. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that that the recommendations contained in Council on Medical Service Report 4 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 4 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 4 contains recommendations for 50 socioeconomic policies adopted or reaffirmed by the House in 2002.

There was limited testimony on Council on Medical Service Report 4. The Chair of the Council on Medical Service introduced the report and noted the Council's efforts to review and analyze the 50 policies that it was assigned. Testimony agreed with the recommendation of the Virtual Reference Committee report that Policy H-180.954 be retained and also recommended retaining Policies H-225.964, H-225.973, H-285.979 and H-335.964. Your Reference Committee concurs that these additional policies noted in testimony should be retained and recommends that Council on Medical Service Report 4 be adopted as amended.

(11) RESOLUTION 702 - IMPROVED ADEQUACY OF TRANSLATION SERVICES IN HOSPITAL AND PHARMACY SETTINGS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 702 be amended by insertion and deletion on lines 14 – 17 to read as follows (Reference Committee changes shown as double strikethrough and double underline):

H-215.982 ~~Translator~~ Interpretive Services in Hospitals: Our AMA encourages ~~hospitals~~ hospitals ~~health care institutions, including but not limited to hospitals~~ and pharmacies, that serve populations with a significant number of non-English speaking ~~or hearing-impaired~~ patients to provide trained ~~translator~~ interpretive services. (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 702 be amended by addition of a new resolve to read as follows:

RESOLVED, That Policy D-160.992 "Appropriate Reimbursement for Language Interpretive Services" be reaffirmed (Reaffirm HOD Policy).

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

Resolution 702 asks that our AMA amend Policy H-215.982 by deletion and insertion to read as follows:

H-215.982 Translator Services in Hospitals: Our AMA encourages hospitals health care institutions, including but not limited to hospitals and pharmacies, that serve populations with a significant number of non-English speaking patients to provide trained translator services.

There was mixed testimony on Resolution 702. Some testified that amended language “health care institutions” is problematic and could be construed to expand the existing unfunded mandate for physicians to provide translators. Others suggested limiting the amendment to only include pharmacies. There was also mixed testimony on the merits of trained translator services, which your Reference Committee notes is fully discussed in previous reports (see Council on Medical Service 5-A-11). Your Reference Committee acknowledges testimony that “interpretive services” is more accurate than translator services. In addition, your Reference Committee recognizes the need to eliminate the financial burden across medical settings for the cost of interpretive services for patients who do not speak English or are hearing impaired. However, without funding for the federal mandate to provide interpreter services, your Reference agrees that our AMA should continue to work to repeal the mandate. Therefore, your Reference Committee recommends that Resolution 702 be adopted as amended and that Policy D-160.992 be reaffirmed.

D-160.992 Appropriate Reimbursement for Language Interpretive Services

Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English. (Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10)

- (12) RESOLUTION 709 - INSURANCE COMPANY DENIALS
RESOLUTION 712 - REGULATION AND TRANSPARENCY OF
RADIOLOGY AND RADIOLOGY BENEFIT MANAGER'S CONTRACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 709 be adopted in lieu of Resolutions 709 and 712.

HOD ACTION: Substitute Resolution 709 adopted in lieu of Resolutions 709 and 712.

APPROPRIATE USE OF PREAUTHORIZATION

RESOLVED, That our AMA notify state and specialty societies of the model legislation developed by the Advocacy Resource Center titled “Appropriate Use of Preauthorization Act” (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm the following policies:

- H-285.931 The Critical Role of Physicians in Health Plans and Integrated Delivery Systems;
- H-285.998 Managed Care;
- H-320.945 Abuse of Preauthorization Procedures;
- H-320.946 Radiology Benefits Manager;
- H-320.952 External Grievance Review Procedures; and
- H-320.968 Approaches to Increase Payer Accountability (Reaffirm HOD Policy).

Resolution 709 asks that our AMA adopt as policy that when a curative or major quality of life changing treatment is denied by an insurance company, that the appeal process must involve a physician with specialty certification in the requesting physician’s specialty; advocate for legislation to ensure that a fair and just insurance appeals process is available at the national level; and encourage its constituent societies to advocate for a fair and just insurance appeals process at the state and local levels.

Resolution 712 asks that our AMA work through regulatory and/or legislative means to establish that authorization criteria for cardiology and radiology services be appropriate, transparent, published, in line with established appropriate standards of care, and consistent with established practice guidelines; work through regulatory and/or legislative means to establish an expedited appeals process that includes immediate access to specialty specific peer-to-peer review; and advocate for legislative and/or regulatory oversight and transparency of all contracts between third party payers and cardiology and radiology benefits managers to assure that there are not perverse incentives to deny appropriate care.

There was generally supportive testimony on Resolutions 709 and 712. There was testimony that the model legislation developed by the AMA Advocacy Resource Center titled "Appropriate Use of Preauthorization Act" addresses the issues outlined in these resolutions. However, it was also noted that state and specialty societies may not be aware of this resource, which would serve to be very helpful in state advocacy efforts. Your Reference Committee believes that increasing the awareness of state and specialty societies of the model legislation is critical. In addition, your Reference Committee notes that the AMA's private sector advocacy efforts have been focused on the issues outlined in Resolutions 709 and 712. The Patient Protection and Affordable Care Act (ACA) also included provisions providing for internal appeals and external review.

Importantly, the AMA already has policy addressing the intent of Resolutions 709 and 712, which has served as the foundation upon which AMA advocacy efforts on the state and federal levels, as well as in the private sector, have been based. Therefore, as part of the substitute resolution, your Reference Committee recommends the reaffirmation of Policies H-285.931, H-285.998, H-320.945, H-320.946, H-320.952 and H-320.968. For longer policies, pertinent passages are in bold font.

H-285.931 The Critical Role of Physicians in Health Plans and Integrated Delivery Systems
Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS): (1) Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing body or management; (b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes; (c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine; (d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and (e) have access to a due process system. (2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process. (3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols. (4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions. **(5) Practicing physicians and patients of a health plan/IDS should have access to a timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.** (6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care. (7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data. (8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to

identify, improve and document cost/quality relationships that demonstrate value. (9) Physician representatives/leaders must communicate key policies and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative. (10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice. Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems. (Res. 706, I-98; Reaffirmation A-99; Reaffirmation A-07)

H-285.998 Managed Care

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing. (2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population. (3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees. (4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings. With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. **The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care. Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.** (5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. **A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or**

providing the reviewed service and should be professionally and individually accountable for his or her decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan. All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient. When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage." **Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services.** Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process. (Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11)

H-320.945 Abuse of Preauthorization Procedures

Our AMA opposes the abuse of preauthorization by advocating the following positions: (1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen. (2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial. (Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11)

H-320.946 Radiology Benefits Manager

Our American Medical Association: (1) strongly encourages radiology benefits managers (RBMs) to adhere to uniform physician-developed best practice guidelines; (2) supports the use of appropriate use criteria developed by physicians with relevant expertise working in a collaborative process involving all national medical specialty societies that provide and/or order the imaging service in question; (3) supports an independent study assessing the magnitude of the cost and administrative burden of imaging utilization strategies on ordering physician offices, imaging providers, and patients and the impact these strategies have on patient safety and outcomes; (4)

strongly encourages each radiology benefit manager (RBM) to publish and distribute the specific diagnostic codes used by their firm to approve or disapprove specific imaging procedures. This information should be distributed by the RBM via electronic or paper means to each physician who is credentialed to participate on health plans that utilize that particular RBM; (5) opposes the practice of forced test substitution and arbitrary denial of requested imaging services by RBMs contracted by third-party payers that meet appropriate use criteria, and that RBMs be held accountable for harm caused by substitution or delay of requested studies; and (6) encourages the Physician Consortium for Performance Improvement® to continue to develop patient-centered measures, including those that address the appropriate use of imaging. (CMS Rep. 5, I-09)

H-320.952 External Grievance Review Procedures

Our AMA establishes an External Grievance Review procedure for all health plans with the following basic components: (1) It should apply to all health carriers; (2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician; (3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational; (4) Internal grievance procedures should generally be exhausted before requesting external review; (5) An expedited review mechanism should be created for urgent medical conditions; (6) Independent reviewers practicing in the same state should be used whenever possible; (7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review; (8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information; (9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine. (Res. 701, I-98; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10)

H-320.968 Approaches to Increase Payer Accountability

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. (1) **Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on** (a) coverage provisions, benefits, and exclusions; **(b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient;** (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97) (2) **Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:** (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; **(c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review;** (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed;

(e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay. (3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11)

(13) RESOLUTION 718 - STRENGTHENING MEDICOLEGAL DEATH INVESTIGATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 718 be amended by deletion of the second Resolve on lines 26-28 to read as follows:

~~RESOLVED, That our AMA support the statement that "it is necessary to strengthen the professional community and medicolegal death investigations" (New HOD Policy); and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the third Resolve of Resolution 718 be amended by insertion and deletion on lines 30-32 to read as follows:

~~RESOLVED, That our AMA work with interested states on develop model medical examiner legislation to facilitate the transition from coroner systems to medical examiner systems where appropriate.~~
(Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 718 be adopted as amended.

HOD ACTION: Resolution 718 adopted as amended.

Resolution 718 asks that our AMA affirm that it is necessary to strengthen the professional community and medicolegal death investigations, and develop model medical examiner legislation to facilitate the transition from coroner systems to medical examiner systems where appropriate.

Your Reference Committee heard mixed testimony on Resolution 718. The author of the resolution spoke in favor of the original wording of the third resolve, versus the amended wording proposed by the Reference Committee in its Virtual Reference Committee report. However, testimony in the support of the amendment stressed that the amendment would allow for state flexibility in approaching this issue, which is critical as states differ in their ability to direct financial resources toward facilitating the transition from coroner systems to medical examiner systems. Your Reference Committee believes that amending the third resolve will result in the strongest approach to tackling this issue on the state level, while respecting the diversity of state approaches to coroner and medical examiner systems. Your Reference Committee also recommends striking the second resolve as existing policy suggested for reaffirmation in the first resolve, as well as the third resolve as amended, sufficiently convey the intent of the resolution.

- (14) RESOLUTION 722 - COST AND BENEFIT ANALYSIS FOR ELECTRONIC HEALTH RECORD IMPLEMENTATION
RESOLUTION 725 – UNDERSTANDING THE PITFALLS OF ELECTRONIC HEALTH RECORDS AND PROVIDING STRATEGIES FOR SUCCESS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 722 be adopted in lieu of Resolutions 722 and 725.

HOD ACTION: Resolutions 722 and 725 referred.

SURVEYING PHYSICIANS ON ELECTRONIC HEALTH RECORD IMPLEMENTATION

RESOLVED, That our AMA work in collaboration with AmericanEHR Partners to expand its upcoming survey on electronic health records (EHRs) to incorporate questions such as, but not limited to, addressing the impact of using EHRs on quality of care, practice expenses, productivity and physician payment. (Directive to Take Action)

Resolution 722 asks that our AMA conduct a comprehensive literature review and/or study to analyze the current cost and/or benefit of implementing an electronic health record (EHR) for physicians in the ambulatory setting to determine if practices are able to realize a financial return on investment and an increase in quality of care from their EHR, and advocate for the position that the parties benefiting most financially from the implementation of EHRs must share fairly in the cost.

Resolution 725 asks that our AMA survey physicians in private practice with regard to the impacts of using electronic medical records (EMRs); survey experienced EMR users with regard to strategies that have been effective in addressing the potential pitfalls of EMRs; survey physician scribes as a way of improving the use of the EMR, improving office efficiency, and more accurately and completely documenting patient visits; and make available the results of its surveys on physician experiences with EMRs, and report back at the 2013 Annual Meeting.

There was limited and mixed testimony on Resolution 722. While there was support for the availability of information concerning the costs and benefits of implementing an EHR, there was also testimony that noted that the study called for in this resolution is already being done. Speakers also raised concern with the fiscal note of the resolution.

Your Reference Committee heard generally supportive testimony on Resolution 725. However, a speaker noted that the AMA is cooperating with AmericanEHR Partners for an upcoming, comprehensive survey of physicians using the AmericanEHR Partners survey instrument that has been in use for more than four years. The American College of Physicians and Cientis Technologies were co-founders of AmericanEHR Partners, a web-based resource for the selection and implementation of EHR systems. In that light, your

Reference Committee believes that this upcoming survey can serve as a vehicle through which the concerns outlined in Resolutions 722 and 725 can be addressed, versus launching a new survey or studies that may serve to be duplicative. Therefore, your Reference Committee recommends that Substitute Resolution 722 be adopted.

(15) RESOLUTION 701 - EFFECT OF COMPUTERS IN THE EXAM ROOM
ON PHYSICIAN-PATIENT COMMUNICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 701 be referred.

HOD ACTION: Resolution 701 referred.

Resolution 701 asks that our AMA study the effect of electronic devices, including but not limited to computers and tablets, in the exam room on doctor-patient communication with an emphasis on alternatives and modifications that might improve the physician-patient relationship.

Testimony on Resolution 701 was mixed. The sponsor of the resolution supported its adoption versus referral. Testimony noted that academic institutions are engaged in studies similar to that called for in the resolution. The bulk of testimony generally supported referral, but stressed that the AMA is not the best entity to conduct primary research studies, and fiscal resources should not be used to duplicate information that is already available. A member of the Council on Medical Education agreed and suggested that the Council could undertake a literature review to summarize existing and ongoing research in addition to best practices. Other speakers requested that research highlight physician multi-tasking and investigate how scribes might be integrated in a cost effective way. Your Reference Committee agrees that a white paper or other relevant educational resources could provide useful information for physicians. Therefore, your Reference Committee recommends that Resolution 701 be referred.

(16) RESOLUTION 707 - ADVOCACY FOR MEDICARE/MEDICAID
COVERAGE OF MULTI-USE TECHNOLOGY PLATFORMS FOR
AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be referred.

HOD ACTION: Resolution 707 referred.

Resolution 707 asks that our AMA support promoting the medical application of consumer technologies through new strategies for reimbursing the functionality software for multi-use platforms.

Your Reference Committee heard limited testimony on Resolution 707. The author of Resolution 707 requested new strategies for Medicare and Medicaid reimbursement for medical applications hosted on multi-purpose consumer electronics. Your Reference Committee believes that a report could address several complex issues such as potential payment options for consumer electronics and associated medical applications. Therefore, your Reference Committee recommends that Resolution 707 be referred.

(17) RESOLUTION 708 - ACCURATE EVALUATION OF PAIN CONTROL DURING HOSPITAL VISITS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 708 be referred.

HOD ACTION: Resolution 708 referred.

Resolution 708 asks that our AMA work with the Centers for Medicare & Medicaid Services to support the development of an accurate and meaningful evaluation tool to assess pain control and management during hospital and emergency department visits as well as remove reimbursement decisions that are related to such subjective surveys.

Testimony on this resolution was generally in support of referral. Your Reference Committee agrees that this resolution raises a host of complex issues, for which additional study is needed, and therefore recommends that Resolution 708 be referred.

(18) RESOLUTION 710 - SUPPORT INTEGRATION OF CARE FOR RETURNING MILITARY, VETERANS AND THEIR FAMILIES BY OPENING ACCESS TO THE STATES' PRESCRIPTION MONITORING PROGRAMS BY VA PRESCRIBING PROVIDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 710 be referred.

HOD ACTION: Resolution 710 referred for decision.

Resolution 710 asks that our AMA advocate to the Department of Veterans Affairs that VA health care providers be permitted to utilize Prescription Monitoring Program sites; and increase collaborations with the VA and Veterans Service Organizations to encourage community-based efforts between VA and non-VA based physicians and state operated Prescription Monitoring Programs.

There was testimony in support of the intent of Resolution 710. However, there were several calls for referral due to the complexity of the issues outlined in the resolution. While there have been developments in allowing the VA to participate in State Prescription Drug Monitoring Programs, speakers highlighted the issue of non-VA physicians being unable to access the VA drug monitoring system. Your Reference Committee agrees that bidirectional information exchange is a major problem. Speakers also stressed that the title of the resolution does not adequately reflect the scope of the resolution, which impacts all veterans. Your Reference Committee agrees with testimony that this is a critical issue for physicians, is a complex issue, and greatly impacts patient safety. Therefore, your Reference Committee recommends referral of Resolution 710.

(19) RESOLUTION 711 - WEB-BASED TELE-HEALTH INITIATIVES AND POSSIBLE INTERFERENCE WITH THE TRADITIONAL PHYSICIAN-PATIENT RELATIONSHIP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 711 be referred.

HOD ACTION: Resolution 711 referred.

Resolution 711 asks that our AMA urge the US Department of Health and Human Services to review tele-health initiatives being implemented by major health insurance carriers and others to assure that proper standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations, and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and regulations; and seek regulatory guidance from HHS regarding the essential requirements of web-based tele-health technology and health care initiatives and the requirements of physicians and healthcare providers who engage in the delivery of such services.

There was mixed testimony on Resolution 711. Several speakers testified in support of reaffirmation. Those who spoke in opposition to reaffirmation voiced significant concerns with insurer tele-health products and asked for guidance not only from the AMA, but the federal government. Other speakers agreed with these concerns, but questioned whether the federal government should interfere in the patient-physician relationship. Your Reference Committee believes that the concerns raised by Resolution 711 merit additional study, and agrees that physicians would benefit from guidance developed by physicians rather than the federal government. Therefore, your Reference Committee recommends that Resolution 711 be referred.

(20) RESOLUTION 716 - REMOVE FACE-TO-FACE INTERACTION
REQUIREMENT FOR CERTIFICATION OF HOME HEALTH NEEDS
RESOLUTION 723- FACE TO FACE ENCOUNTER FORMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 716 and 723 be referred.

HOD ACTION: Resolutions 716 and 723 referred.

Resolution 716 asks that our AMA work with the Centers for Medicare & Medicaid Services to study alternatives to the requirements for face-to-face interaction to certify the need for home health care services to better address the issue of patients who could benefit from these services but who may not be able to present at the doctor's office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office.

Resolution 723 asks that our AMA seek, through all appropriate means, to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care is responsible for completing the Face to Face Encounter form.

There was supportive testimony on the intent of Resolution 716. Testimony was also generally supportive of referring this resolution, as the topic of this resolution is currently under study by the Council on Medical Service. Your Reference Committee reports that since the enactment of the Affordable Care Act, which included the face-to-face encounter requirement for Medicare home health services, the AMA has engaged in efforts to minimize the provision's burden on physicians. For example, as a result of successful AMA advocacy, the Centers for Medicare and Medicaid Services does not require a particular form to be used to document the face-to-face requirement.

There was mixed testimony on Resolution 723. Testimony in support of the resolution stressed that the provider who actually discharges the patient should be required to complete the face-to-face encounter documentation, which would ensure that patients would have access to needed home health services without delay. However, other testimony underscored that the resolution may have unintended consequences.

Members of the Council on Medical Service welcomed referral of Resolutions 716 and 723, as it is drafting a report on this topic for the 2012 Interim Meeting. Your Reference Committee agrees that referral of Resolutions 716 and 723 is warranted so that the issues raised in the resolutions can be

thoroughly studied by the Council on Medical Service and considered in the context of its upcoming report.

(21) RESOLUTION 724 – AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 724 be referred.

HOD ACTION: Resolution 724 referred.

Resolution 724 asks that our AMA adopt as policy the listed *AMA Principles for Physician Employment*.

Your Reference Committee heard generally supportive testimony on this resolution. Your Reference Committee recognizes the tremendous effort by the Organized Medical Staff Section in developing the principles for physician employment recommended for adoption in this resolution. The sponsor of the resolution noted that the OMSS worked with other entities in the AMA to develop the proposed principles, and it has been vetted by the AMA Office of General Counsel. However, some speakers noted that the principles may be in conflict with existing state initiatives on this issue. Speakers also noted the length of the resolution, the complexity of the matter, and the lack of time the House of Delegates had to review this resolution. Accordingly, some speakers called for referral. Your Reference Committee concurs that Resolution 724 should be referred, so that delegates have ample opportunity to review the ensuing report.

(22) RESOLUTION 704 - PHYSICIAN LED QUALITY IMPROVEMENT PROJECTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-450.983, D-478.984 and H-450.946 be reaffirmed in lieu of Resolution 704.

HOD ACTION: HOD Policies D-450.983, D-478.984 and H-450.946 reaffirmed in lieu of Resolution 704.

Resolution 704 asks that our AMA gather a repository of Quality Improvement Project (QIP) quality measures and financial benefits by identifying and contacting physician QIP leaders and inviting them to contribute their prior and ongoing data from QIP for analysis of QIP quality measures and financial benefits, for eventual review by other physicians to approximate how a similar project could benefit their own healthcare organization.

There was mixed testimony on Resolution 704. Representatives of the AMA-convened Physician Consortium for Performance Improvement (PCPI) spoke in favor of the recommendation proposed by the Reference Committee in its Virtual Reference Committee report to reaffirm existing AMA policy in lieu of Resolution 704. Representatives of the PCPI noted that the creation of the repository called for in Resolution 704 would duplicate existing efforts associated with PCPI's new quality improvement initiatives, and that the National Quality Forum is also addressing the issues outlined in the resolution. They also noted that the PCPI is engaged in activities to educate physicians and patients. Speakers were also concerned with the resolution's fiscal note. Responding to testimony, the author of the resolution suggested amended language, which, according to a PCPI representative, only represents one piece of many activities taking place in the quality improvement arena.

While appreciating the intent of Resolution 704, your Reference Committee concurs with testimony of the PCPI representatives that the AMA should continue its efforts in quality improvement, especially within the context of payment and delivery reform. In addition to the work underway by AMA-convened PCPI in quality improvement, the AMA has also established the Innovators Committee, an advisory group of physicians with hands-on experience in the development and management of innovative delivery and payment models. Their experience guides the development of AMA resources to help physicians enact innovations that improve patient care and increase their professional satisfaction and success. As part of the work of the Innovators Committee, the AMA is seeking to identify other innovative reforms taking place around the country that are being developed and led by physicians. Considering the array of activities ongoing at the AMA addressing quality improvement, which are based on existing policy, your Reference Committee recommends that Policies D-450.983, D-478.984 and H-450.946 be reaffirmed in lieu of Resolution 704.

D-450.983 Expansion of Scope of Activities of AMA Physician Consortium for Performance Improvement

Our AMA will: (1) expand the AMA Physician Consortium for Performance Improvement (Consortium) to include representatives from all national medical specialty societies and state medical societies who wish to participate; (2) expand the scope of the Consortium to include development of clinical performance measures, validation of clinical performance measures, and direction on appropriate implementation of clinical performance measures; (3) study and prepare a report to clarify the role and authority of the National Quality Forum and identify pathways that may allow the Consortium and physicians to have greater influence in the validation of clinical performance measures; (4) continue to advocate for the AMA-convened Physician Consortium for Performance Improvement (PCPI) as a leading measure development organization that addresses measures of underuse, overuse, and appropriateness; (5) continue to engage with the national medical specialty society members of the PCPI to identify topics to expand the PCPI portfolio of quality measures addressing, in particular, overuse and appropriateness; (5) engage national medical specialty societies who are leaders with the PCPI in developing measures of overuse and appropriateness to submit editorials and distribute society member communications announcing the availability and importance of these measures developed by the profession; (7) continue to seek opportunities to align measures of quality with measures of cost; and (8) ensure that the PCPI provides opportunities for active involvement by all affected specialties in the measure development and approval process." (Res. 601, I-05; Appended: BOT Rep. 17, A-11)

D-478.984 Clinical Data Repositories for Physicians, Patients and Continuous Quality Improvement

Our American Medical Association will (1) collect and make available the best practices resulting from existing pilot Clinical Data Repository (CDR) projects to demonstrate the most appropriate measures and data aggregation methods for assessing physician performance, and to demonstrate how best to use clinical data to improve quality of patient care; and (2) identify and disseminate educational materials to be used by physician organizations and communities on how to best use data from CDRs in practice improvement, quality improvement, and contracting. (BOT Rep. 3, I-09)

H-450.946 Ensuring Quality in Health System Reform

Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop

principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles. (Sub. Res. 703, I-93; Reaffirmation A-01; Renumbered: CMS Rep. 7, I-05)

(23) RESOLUTION 705 - OPTING OUT OF HEALTH INFORMATION EXCHANGES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-478.988 and H-315.983 be reaffirmed in lieu of Resolution 705.

HOD ACTION: HOD Policies D-478.988 and H-315.983 reaffirmed in lieu of Resolution 705.

Resolution 705 asks that our AMA include in its current ongoing study of health information exchanges, concern for potential risks to patient privacy and safeguards against compromise of patient information.

Testimony on this item was limited the author of the resolution, who noted that the AMA needs to have a policy stance concerning patient privacy and safeguards against compromise of patient information in health information exchanges. Your Reference Committee believes that Policies D-478.988 and H-315.983 address the intent of this resolution, and therefore recommends that they be reaffirmed in lieu of Resolution 705. For longer policies, pertinent passages are in bold font.

D-478.988 Studying and Supporting Health Information Exchange

1. Our AMA will: (A) study existing health information exchange pilots, create a report for the 2008 Interim Meeting that specifically outlines the ways in which a health information exchange might be used to maximally benefit physicians and their patients and includes ways in which the AMA might apply its resources to assist in the further study and eventual realization of those benefits; and (B) explore ways to help our members have access to and/or share aggregated practice performance data including claims-based and clinical information. 2. **Our AMA will study issues related to how best to protect the legitimate interests of patients and physicians regarding clinical data that is sent to and received from a health information exchange (HIE), particularly in regards to payers and their access to and use of clinical data obtainable via an HIE, and develop policies and standards regarding HIE data, and possible model legislation, with attention to:** (A) who owns the clinical data that is passed to and from an HIE; (B) what types of parties have a legitimate interest in obtaining clinical data from HIEs, and for what purposes; (C) who may determine what data is made available to whom; (D) what constraints should properly be placed on the use of clinical data in an HIE; (E) ensuring that at a very minimum, no payer would be allowed to obtain identifiable clinical data on individuals who are not currently insured members of a health plan belonging to that payer, with the possible exception of informed consent having been signed by a patient as part of an application for acceptance of that patient by a specified health plan, if such underwriting were once again allowed by law; (F) how policies and standards for data sharing and access should differentiate between individually identifiable patient data and de-identified or aggregated patient data; (G) standards for de-identified and aggregated data to protect against reverse engineering to re-identify clinical data, especially where data relates to rare diseases or comes from rural areas; (H) policies for data sharing and access that specifically address data use for mandated reporting, "care management", research, and proprietary purposes; (I) informed consent for sharing of data: what such informed consent should include and who should be tasked to obtain it; (J) possible model state legislation to define accountability for clinical data use in an HIE and to ensure that those policies that are essential to protect patients and physicians can be legally enforceable; and **(K) privacy issues including genetic testing, mental health disorders and substance use disorders.** (Res. 722, A-08; Appended: Res. 710, A-11)

H-315.983 Patient Privacy and Confidentiality

(1) Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. (2) Our AMA affirms: (a) that physicians who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. (3) Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients and physicians should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. (5) **The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.** (6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. (7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. (8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. (9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. (10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. (11) Marketing and commercial uses of identifiable patients' medical information may violate principles

of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures (12) **Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including:** (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) **The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.** (13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. (14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. (15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. (16) The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. (17) Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. (18) Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. (19) Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. (20) Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. (BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11)

(24) RESOLUTION 706 - SUPPORTING THE VALUE AND ADOPTION OF POPULATION HEALTH MANAGEMENT STRATEGIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-155.960 and H-160.919 be reaffirmed in lieu of Resolution 706.

HOD ACTION: HOD Policies H-155.960 and H-160.919 reaffirmed in lieu of Resolution 706.

Resolution 706 asks that our AMA affirm the value and effectiveness of physician-led, team-based care models employing population health management strategies to achieve the Triple Aim goals of better health, better care and reduced health care costs.

Testimony on Resolution 706 was limited. The sponsor of the resolution supported the recommendation of the Virtual Reference Committee report to reaffirm existing policy in lieu of the resolution. In addition,

the Chair of the Council on Medical Service testified that the Council on Medical Service is working in conjunction with the Council on Medical Education to develop a report on physician-led, team-based care models for the 2012 Interim Meeting. Therefore, your Reference Committee recommends that Policies H-155.960 and H-160.919 be reaffirmed in lieu of Resolution 706.

H-155.960 Strategies to Address Rising Health Care Costs

Our AMA: (1) recognizes 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) supports the following broad strategies for addressing rising health care costs: (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) will 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) will 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) will 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 other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages 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) encourages 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) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation A-09; Reaffirmation I-09; Reaffirmation A-11; Reaffirmation I-11)

H-160.919 Principles of the Patient-Centered Medical Home

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows: Principles Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the

attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. It should support adoption and use of health information technology for quality improvement. It should support provision of enhanced communication access such as secure e-mail and telephone consultation. It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements. 2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care. 3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home. 4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes. 5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home. (Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11)

(25) RESOLUTION 714 – ELECTRONIC HEALTH RECORD VENDOR CONTRACTING POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-478.996 and D-478.995 be reaffirmed in lieu of Resolution 714.

HOD ACTION: HOD Policies D-478.996 and D-478.995 reaffirmed in lieu of Resolution 714.

Resolution 714 asks that our AMA study the issue of electronic health record (EHR) data conversions and all associated costs, and present a report at the 2012 Interim Meeting that provides potential solutions to allow physicians to switch to a different EHR product without excessive cost, delay, or loss of patient data.

There was limited yet supportive testimony on Resolution 714. The author of the resolution spoke in support of the recommendation contained in the Virtual Reference Committee report to reaffirm existing policy in lieu of Resolution 714. Your Reference Committee notes that existing AMA policy focusing on interoperability of EHR products and minimizing the financial burden to physician practices of adopting and maintaining electronic medical records addresses the intent of Resolution 714. Following the adoption of existing policy, the AMA has been engaged with the Centers for Medicare & Medicaid Services, the Office of the National Coordinator for Health Information Technology, and other entities to ensure that EHR products are interoperable and usable. Therefore, your Reference Committee recommends that the following policies be reaffirmed in lieu of Resolution 714:

D-478.996 Information Technology Standards and Costs

Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11)

D-478.995 National Health Information Technology

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of EMR user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EMR user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care. (Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11)

(26) **RESOLUTION 715 - ELECTRONIC MEDICAL RECORD COMMUNICATION**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-478.996 and D-478.995 be reaffirmed in lieu of Resolution 715.

HOD ACTION: HOD Policies D-478.996 and D-478.995 reaffirmed in lieu of Resolution 715.

Resolution 715 asks that our AMA convene a meeting of electronic medical record (EMR) vendors to propose a method of communications among their EMR systems.

There was limited yet supportive testimony on Resolution 715 on the Virtual Reference Committee site, and no testimony at the live hearing. Based on existing AMA Policies D-478.996 and D-478.995, the AMA has continued its efforts promoting the need for greater interoperability and standardization between EMR systems, as well as standards for exchanging health information. Your Reference Committee notes that work related to the intent of this resolution is already mandated by law and underway at the US Department of Health & Human Services, arguably a more appropriate convener of all stakeholders in the arena of health information technology. Therefore, your Reference Committee recommends reaffirmation of Policies D-478.996 and D-478.995 in lieu of Resolution 715.

D-478.996 Information Technology Standards and Costs

Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11)

D-478.995 National Health Information Technology

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of EMR user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EMR user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care. (Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11)

(27) RESOLUTION 717 - DOCTOR'S RATING WEBSITE AND ONLINE REPUTATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-478.980 and D-478.989 be reaffirmed in lieu of Resolution 717.

HOD ACTION: HOD Policies D-478.980 and D-478.989 reaffirmed in lieu of Resolution 717.

Resolution 717 asks that our AMA develop tools in a timely manner to help physicians defend their online reputation and help restore physicians' reputations.

Testimony on Resolution 717 was mixed. Some testified that the resolution should be reaffirmed and highlighted Policies D-478.980 and D-478.989, which support initiatives to identify and offer tools to

physicians that allow them to manage their online profile and presence. Others favored adoption and noted that although the AMA offers an online reputation defense tool, Reputation.com, as part of the discount Member Value Program, the resolution provides a vehicle to promote this member benefit to the House of Delegates. Your Reference Committee believes that consistent with Policy D-478.980[2], the AMA will continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence. As the proposed resolution would create redundant AMA policy, your Reference Committee recommends that Policies D-478.980 and D-478.989 be reaffirmed in lieu of Resolution 717.

D-478.980 Anonymous Cyberspace Evaluations of Physicians

Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys. (BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10)

D-478.989 Accuracy of Internet Physician Profiles

Our AMA will investigate: (1) the publication of physician information on Internet Web sites; and (2) potential solutions to erroneous physician information contained on Internet Web sites with report back at the 2008 Interim Meeting. (Res. 612, A-08; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10)