

REPORTS OF REFERENCE COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES 2015 ANNUAL MEETING

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

(1) BOARD OF TRUSTEES REPORT 2 - NEW SPECIALTY ORGANIZATIONS
REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 2 adopted and the remainder of the report filed.

Board of Trustees Report 2 recommends that the American Association for Geriatric Psychiatry and the American Society of Breast Surgeons be granted representation in our AMA House of Delegates.

All testimony provided was in favor of this report. Testimony from multiple delegations thanked the committee, and looked forward to participation in the House of Delegates. Your Reference Committee recommends that Board of Trustees Report 2 be adopted.

(2) BOARD OF TRUSTEES REPORT 13 - METHODS TO INCREASE US
ORGAN DONOR POOL

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 13 be adopted and 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 responds to Resolution 1-A-14 which asked our American Medical Association to study potential models for increasing the United States organ donor pool. In order to encourage increased levels of organ donation in the United States, this report recommends that our AMA should (1) support studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urge development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs; and (3) encourage the continued study of ways to enhance the allocation of donated organs and tissues.

All testimony provided was in favor of this report. Most of the testimony spoke highly of the report, expressly calling it admirable. In particular, testimony supported the report because it will benefit ethnic minorities who often face barriers to care and higher rates of diseases. Additional testimony touched on personal experiences with transplants, further highlighting the importance of this report. Your Reference Committee recommends that Board of Trustees Report 13 be adopted.

(3) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 -
REPRESENTATIVES TO RFS ASSEMBLY MEETINGS: AMENDED
BYLAWS

RECOMMENDATION:

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

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

Council on Constitution and Bylaws Report 1 recommends that our AMA House of Delegates rescind Policy D-615.979 and amend Bylaw 7.1.3.2, 7.1.3.3, 7.1.3.4, and 7.1.3.5 to remain consistent with other provisions by allowing residents or fellows from constituent associations, national medical specialty societies, professional interest medical associations, or the federal services to participate in the RFS.

All testimony provided was in favor of this report. Testimony thanked the committee and complimented the report's use of greater inclusivity for representatives to RFS Assembly meetings. Your Reference Committee recommends that Council on Constitution and Bylaws Report 1 be adopted.

(4) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2 – OUTDATED BYLAW LANGUAGE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Constitution and Bylaws Report 2 adopted and the remainder of the report filed.

Council on Constitution and Bylaws Report 2 recommends that the House of Delegates remove the outdated *American Medical News* from AMA Bylaw 1.1.1.4 as a benefit of membership.

The Council on Constitution and Bylaws introduced this report and there was no further testimony. Your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted.

(5) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 4 - CLARITY OF AMA BYLAWS - COUNCIL SERVICE FOR STUDENTS AND RESIDENTS AND ASSUMPTION OF COUNCIL SERVICE FOR ALL COUNCIL MEMBERS

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 that the House of Delegates adopt changes to AMA Bylaw 6 to clarify the assumption of service for Council Members and explain the "grace period" provision for medical students and residents/fellows.

All testimony provided was in favor of this report. Testimony thanked the Council on Constitution and Bylaws for clarity of the Bylaw. Your Reference Committee recommends that Council on Constitution and Bylaws Report 4 be adopted.

(6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 5 - CEJA
SUNSET REVIEW OF 2005 HOUSE POLICIES

RECOMMENDATION:

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

HOD ACTION: Council on Ethical and Judicial Affairs Report 5 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 5 presents the annual sunset report of House policies. This report reviewed House policies from 2005. This report recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated.

The Council on Ethical and Judicial Affairs introduced this report and there was no further testimony. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 5 be adopted.

(7) RESOLUTION 2 - AMA PARLIAMENTARY AUTHORITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 2 be adopted.

HOD ACTION: Resolution 2 adopted.

Resolution 2 recommends that the House of Delegates amend AMA Bylaw 11.1 to reference work from The American Institute of Parliamentarians.

All testimony provided was in favor of this resolution. Your Reference Committee recommends that Resolution 2 be adopted.

(8) RESOLUTION 3 - PROPOSED REVISIONS TO THE BYLAWS OF THE SECTION ON MEDICAL SCHOOLS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 3 be adopted.

HOD ACTION: Resolution 3 adopted.

Resolution 3 asks that our AMA Section on Medical Schools (AMA-SMS) be renamed the American Medical Association Academic Physicians Section (AMA-APS) and that our AMA Bylaws be revised to clarify membership criteria for the AMA-APS.

Most of the testimony provided was in favor of this resolution. Testimony explained the resolution's purpose is to be more inclusive for educational opportunities outside of traditional academic medical settings. Your Reference Committee recommends that Resolution 3 be adopted.

(9) RESOLUTION 9 - PARENT TO PARENT EDUCATION ON CHILD VACCINATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be adopted.

HOD ACTION: Resolution 9 adopted.

Resolution 9 suggests that our AMA support the development and evaluation of educational efforts, based on scientific evidence and in collaboration with health care providers, which supports parents who want to help educate and encourage parents who are reluctant to vaccinate their children in order to increase child vaccination rates.

All testimony provided was in favor of this resolution. Testimony stated that the American Academy of Pediatrics is working on educational materials that will explain to parents the importance of child vaccinations. Subsequent testimony explained that greater availability of accurate scientific information on vaccinations for parents has been shown to increase immunization rates. Your Reference Committee recommends that Resolution 9 be adopted.

(10) RESOLUTION 10 - ENDING NON-MEDICAL EXEMPTIONS FOR IMMUNIZATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 10 be adopted.

HOD ACTION: Resolution 10 adopted.

Resolution 10 asks our AMA to reaffirm Policy H-440.970, Religious Exemptions from Immunizations, and support legislative efforts at removing non-medical exceptions for immunization.

Testimony provided was unanimously in favor of this resolution. Much of the testimonial support for this resolution was given due to consistencies with policies of other member organizations. Therefore, your Reference Committee recommends that Resolution 10 be adopted.

(11) RESOLUTION 11 - MILITARY MEDICAL POLICIES AFFECTING TRANSGENDER INDIVIDUALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 11 be adopted.

HOD ACTION: Resolution 11 adopted.

Resolution 11 asks our AMA to affirm that there is no medically valid reason to exclude transgender individuals from service in the US military and transgender service members should be provided care according to the same medical standards that apply to non-transgender personnel.

Most testimony provided was in favor of this resolution. Favorable testimony addressed the need for the AMA to take an important stand in accepting diversity and access to care for transgender persons in the military. Some testimony requested a referral of the resolution for further study to ensure the appropriate standards of care for transgender individuals, but rebuttals to these calls for referral explained that a considerable amount of research has already been conducted on the subject. Testimony further illuminated that the ban of transgender individuals from military service has no medical basis. Your Reference Committee recommends that Resolution 11 be adopted.

(12) RESOLUTION 13 - FILMING PATIENTS FOR NEWS OR ENTERTAINMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 13 be adopted.

HOD ACTION: Resolution 13 adopted.

Resolution 13 asks that our AMA adopt policy stating that efforts to disguise a patient do not substitute for the need to obtain consent as outlined in AMA Policy E-5.045 for publication of any material related to the treatment of a patient.

All testimony provided was in favor of this resolution. Testimony expressed discomfort with the practice of face-blurring that is frequently used in medical entertainment shows as a substitution for consent. Further, testimony stated that patient exploitation for entertainment value is reprehensible and against ethical standards. Therefore, your Reference Committee recommends that Resolution 13 be adopted.

(13) RESOLUTION 14 - PROMOTING SAFE EXIT FROM PROSTITUTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 14 be adopted.

HOD ACTION: Resolution 14 adopted.

Resolution 14 recommends that our AMA support efforts to offer individuals a safe exit from prostitution and support programs that prevent prostitution rather than penalize it through criminal conviction and incarceration.

All testimony provided was in favor of this resolution. Strong testimonial support was given on the fear of incarceration that many prostitutes face when seeking medical care. Testimony also addressed the disproportionate impact incarceration has on minorities, ultimately urging support for alternatives to incarceration for prostitution. Further, testimony explained the need for a more compassionate and rehabilitative approaches to dealing with prostitution. Your Reference Committee recommends that Resolution 14 be adopted.

(14) BOARD OF TRUSTEES REPORT 29 - SPECIALTY SOCIETY
REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR
REVIEW

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Recommendation of Board of Trustees Report 29 be amended by addition on page 2, line 30 to read as follows:

1. That The American Academy of Disability Evaluating Physicians, American Academy of Otolaryngic Allergy, American College of Chest Physicians, American College of Legal Medicine, American College of Mohs Surgery, American College of Phlebology, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Congress of Obstetricians and Gynecologists, American Society of Retina Specialists, Society of Hospital Medicine, and Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Recommendation of Board of Trustees Report 29 be adopted by addition and deletion on page 2, lines 35-36 to read as follows:

2. That the Heart Rhythm Society and, the International Society of Hair Restoration Surgery, and the American Society of Hematology be given a grace period of one year to meet the membership requirements to retain their position in the American Medical Association House of Delegates.

RECOMMENDATION C:

Mr. Speaker, you Reference Committee recommends that the third Recommendation of Board of Trustees Report 29 be amended by deletion.

3. ~~That the American Society of Hematology not retain representation in the House of Delegates.~~

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 29 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 29 adopted as amended and the remainder of the report filed.

Board of Trustees Report 29 recommends that The American Academy of Disability Evaluating Physicians, American Academy of Otolaryngic Allergy, American College of Chest Physicians, American College of Legal Medicine, American College of Mohs Surgery, American College of Phlebology, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American Congress of Obstetricians and Gynecologists, American Society of Retina Specialists, Society of Hospital Medicine, and Undersea and Hyperbaric Medical Society retain representation in the AMA House of Delegates. BOT 29 further recommends that the Heart Rhythm Society and International Society for Hair Restoration Surgery be given a grace period of one year to meet the membership requirements to retain their position in the AMA House of Delegates. This report also recommends that the American Society of Hematology not retain representation in the House of Delegates.

Testimony provided on this report was mixed. The American Society of Hematology testified that they have increased their efforts to gain members and currently have 936 members, an 8% increase in the past year alone. They anticipate meeting the 1,000 member minimum requirement within the next year. Testimony that spoke against the report highlighted the desire to provide the American Society of Hematology with a one-year grace period to meet its membership requirements because this group provides the HOD with valuable insight and perspective. Finally, the BOT noted that the first recommendation inadvertently excluded the American College of Surgeons despite their inclusion in the body of the report and the report should be amended to rectify this. Therefore, your Reference Committee recommends that Board of Trustees Report 29 be adopted as amended.

- (15) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 3 - AMENDED BYLAW LANGUAGE TO ACCURATELY DESCRIBE THE FUNCTIONS OF THE COUNCIL ON CONSTITUTION AND BYLAWS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Recommendation of Council on Constitution and Bylaws Report 3 be amended by addition and deletion on page 1, line 26 to read as follows:

6.1.1.3 To draft Constitution and Bylaws language as directed by the House of Delegates or Board of Trustees, or as initiated recommended by the Council for consideration by the House of Delegates.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 3 adopted as amended and the remainder of the report filed.

Council on Constitution and Bylaws Report 3 recommends that the House of Delegates modify AMA Bylaw 6.1 to clarify the responsibilities of the Council on Constitution and Bylaws.

Testimony for this item was limited but favorable, noting that the recommendations put forth in this report delineate current practice. One edit was suggested to change “initiated” to “recommended” in 6.1.1.3 and this change was accepted by the authors of the report and this Reference Committee. Your Reference Committee recommends that Council on Constitution and Bylaws Report 3 be adopted as amended.

(16) RESOLUTION 1 - RULES FOR AMA ELECTIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Resolve, section (7)(a) (page 2, line 43) of Resolution 1 be amended by addition and deletion to read as follows:

(7)(S) The Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials sent available to the House ~~and on the ballot~~ as the representative of that society and not by the state in which the candidate resides;

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Resolve, section (8)(a) (page 2, line 51) of Resolution 1 be amended by addition and deletion to read as follows:

(8)(6) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) standing being present in a receiving line;

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the Resolve, section (10) (page 3, line 23) of Resolution 1 be amended by deletion to read as follows:

(10)(9) Campaign expenditures and activities should be limited to prudent and reasonable levels necessary for adequate candidate exposure to the delegates.
Campaign gifts can be distributed only at the Annual Meeting in the non-official business folder bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to Delegates and Alternate Delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed

~~but are limited to either a button, pin, or sticker, or other low cost item, the maximum cost of which shall be determined by the Speaker of the House.~~ No other campaign memorabilia shall be distributed at any time;

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 1 be adopted as amended.

HOD ACTION: Resolution 1 adopted as amended.

Resolution 1 asks that our AMA amend G-610.020 to codify AMA election rules and announce intended candidacies on AMA's website.

Testimony provided on this resolution largely spoke in favor of adoption, though several amendments were suggested to add greater clarity and transparency to the election rules and their implementation. Your Reference Committee recommends that Resolution 1 be adopted as amended.

(17) RESOLUTION 4 - CONFIDENTIALITY OF ENROLLMENT IN PHYSICIANS (PROFESSIONALS) HEALTH FOUNDATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 4 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with other medical professional organizations, the Federation of State Medical Boards, ~~the American Board of Medical Specialties, and the National Association of Physicians (and other) Health Foundations Federation of State Physician Health Programs~~, to seek and/or support rules and regulations or legislation to provide for confidentiality of fully compliant participants in physician (and similar) health foundations programs or their recovery programs in responding to questions on medical practice or licensure applications

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 4 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with The Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health foundations programs and ~~therefore who~~ do not constitute a current threat to the care of themselves or their patients.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 4 be adopted as amended.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 4 be changed to read as follows:

CONFIDENTIALITY OF ENROLLMENT IN PHYSICIANS
(PROFESSIONAL) HEALTH PROGRAMS**HOD ACTION: Resolution 4 adopted as amended.**

Resolution 4 asks that our AMA work with medical professional organizations to seek and/or support rules and regulations to provide for confidentiality of fully compliant participants in physician health programs or recovery programs in responding to questions on medical practice or licensure applications. Further, it asks that our AMA work with the Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who do not constitute a threat to the care of themselves or their patients.

Testimony for this resolution was predominantly supportive. Testimony focused on the fact that physicians are fearful of seeking treatment for various conditions because of potential ramifications to their practice if their conditions are not kept confidential. This resolution urges confidentiality on licensure applications when a physician is participating in a health program. Some testimony noted that the terminology used in the resolution is incorrect; physician health "foundations" should correctly be called "programs". Other testimony asked the Reference Committee to add several other organizations to those that the AMA should work with as noted in the resolves. Your Reference Committee recommends that Resolution 4 be adopted as amended.

(18) RESOLUTION 5 - PRINCIPLES OF HUMAN SUBJECTS RESEARCH
SHALL APPLY TO ONLINE RESEARCH PROJECTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 5 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association declare social media sites' terms of service as an insufficient proxy for informed consent prior to being enrolled in ~~an~~ any medical experiment; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 5 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA recommend that online social networks provide users with specific informed consent outlining the aims, risks and possible benefits of ~~an~~ any medical experimental study prior to study enrollment.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 5 be adopted as amended.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 5 be changed to read as follows:

PRINCIPLES OF HUMAN SUBJECTS RESEARCH SHALL APPLY TO
ONLINE MEDICAL RESEARCH PROJECTS

HOD ACTION: Resolution 5 adopted as amended.

Resolution 5 asks our AMA to recommend that online social networks provide users with specific informed consent outlining the aims, risks and possible benefits of an experimental study prior to study enrollment.

Testimony on this resolution was mixed. Those speaking in favor of the resolution noted the critical importance of obtaining informed consent before human subjects participate in any type of study, and that the resolution was in line with other AMA policies on informed consent. Testimony against the resolution noted that social media research is generally not medical in nature, and therefore not under the purview of the AMA. In addition, the resolution as presented was too broad and should speak only to medical research, as other types of research (for example, marketing research) may be subject to different standards. Your Reference Committee recommends that Resolution 5 be adopted as amended.

(19) RESOLUTION 6 - PHYSICIAN AND HEALTH INSTITUTION PUBLICITY AND RESPONSIBILITY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 6 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on ~~rigorously tested evidence~~ published peer-reviewed evidence, standard of care, or personal opinion.

RECOMMENDATION B:

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

HOD ACTION: Resolution 6 adopted as amended.

Resolution 6 recommends our AMA encourage physicians engaged in public discourse related to health and medical science to disclose whether stated positions are based on rigorously tested evidence, standard of care, or personal opinion.

Testimony for this resolution was limited but favorable. A recommendation was made to change language in the resolve to read as outlined above, and the amendment was supported. Therefore, your Reference Committee recommends that Resolution 6 be adopted as amended.

(20) RESOLUTION 7 - VACCINATION REQUIREMENTS TO PROTECT ALL CHILDREN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 7 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~provide support the dissemination of~~ materials on vaccine efficacy to states, and encourage them to eliminate philosophical and religious exemptions from state immunization requirements; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 7 be amended by addition and deletion as follows:

RESOLVED, That our AMA recommend that states have in place: (a) an established decision mechanism that involves qualified public health physicians to determine which vaccines will be mandatory for admission to school and

other identified public venues (based upon the recommendations of ACIP and AAP); and (b) exemptions to these immunization mandates only for medical reasons, because disease exposures, importations, infections, and outbreaks may occur without warning in any community, and (c) a procedure whereby a licensed physician may certify a medical exemption using science-based criteria as documented on the vaccine information sheets for specific vaccines (<http://www.cdc.gov/vaccines/hep/vis/>), with state oversight to ensure timeliness and consistency.

RECOMMENDATION C:

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

HOD ACTION: Resolution 7 adopted as amended.

Resolution 7 asks that our American Medical Association provide materials on vaccine efficacy to states and encourage them to eliminate philosophical and religious exemptions from state immunization requirements. It also provides guidelines for medical exemptions and immunization requirements for schools.

Testimony was predominately in favor of this resolution. Specifically, the resolution's aim to support vaccination requirements for all children was unanimous. In addition, testimony noted that a strong policy is needed to remove all nonmedical exemptions and to achieve greater compliance with the recommendations of the Advisory Committee on Immunization Practices. Several amendments were proposed to strengthen the resolves and the resolution as a whole. Therefore, your Reference Committee recommends that Resolution 7 be adopted as amended.

(21) RESOLUTION 8 - PROTECTING PATIENTS AND THE PUBLIC BY
IMMUNIZING PHYSICIANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 8 be amended by addition to read as follows:

RESOLVED, That in the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians and health care workers who have direct patient care responsibilities or potential direct exposure have an obligation to accept immunization unless there is a recognized medical reason to not be immunized. In such scenarios, appropriate protective measures should be taken.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 8 be adopted as amended.

HOD ACTION: Resolution 8 adopted as amended.

Resolution 8 recommends an obligation for physicians to be immunized for transmittable diseases if an immunization exists, unless there is a recognized medical reason to not be immunized.

Testimony for this resolution was favorable, noting that physicians have an obligation to protect the health of patients by getting immunized, and that physicians should also set a good example for patients by getting immunized. An amendment was proposed to include other health care workers who have direct patient contact, and

that physicians who cannot be immunized should take other protective measures to protect the health of patients. Your Reference Committee recommends that Resolution 8 be adopted as amended.

(22) RESOLUTION 12 - ENCOURAGE AUTISM SOCIETY TO SUPPORT VACCINATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 12 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work jointly with the American College of Physicians, American Academy of Pediatrics and American Academy of Family Physicians to ~~strongly~~ encourage the Autism Society of America to ~~prominently~~ display on their website that based on current scientific evidence, autism is not caused by vaccinations, and encourage vaccinations to promote better health for all our population.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 12 be adopted as amended.

HOD ACTION: Resolution 12 adopted as amended.

Resolution 12 asks that our AMA recommend that the Autism Society support vaccinations due to misinformed public opinions on the link between vaccines and autism.

Testimony in support of this resolution was mixed. Those speaking in favor of the resolution stated that it would be a positive step forward for the Autism Society to display this information on their website. However, a variety of concerns were expressed. Some noted that the organization under discussion might be unlikely to pursue such a move, while others stated that the language of the resolution as presented was problematic. Therefore, your Reference Committee recommends that Resolution 12 be adopted as amended.

(23) RESOLUTION 15 - PROGRAMS ON MANAGING PHYSICIAN STRESS AND BURNOUT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 15 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~develop a series of support existing~~ programs to assist physicians in early identification and management of stress;

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 15 be amended by addition to read as follows:

RESOLVED, That the programs supported by the AMA to assist physicians in early identification and management of stress concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 15 be adopted as amended.

HOD ACTION: Resolution 15 adopted as amended.

Resolution 15 recommends that our American Medical Association develop a series of programs to assist physicians in early identification and management of stress.

Testimony for this resolution was favorable, focusing on supporting mental health programs for physicians. However, several people noted that these programs exist both within and outside of the AMA, and thus our AMA does not need to develop any further programs to address this issue. Therefore, your Reference Committee recommends that Resolution 15 be adopted as amended.

(24) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - ETHICAL PRACTICE IN TELEMEDICINE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 1 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 referred.

Council on Ethical and Judicial Affairs Report 1 examines the ethical and professional responsibilities of physicians who practice through telemedicine. Physicians who offer health care services through telemedicine are held to the same standards of care as in traditional health care practice, but they must pay close attention to issues that are particularly relevant with health care provided through new modes of technology such as the patient's right to privacy and issues of informed consent.

Testimony supported referral of this report. Although the intent of the report received positive feedback, testimony indicated that the report should include the dissemination of both positive and negative outcomes of telemedicine. Also, testimony addressed the need for a requirement of an in-person interaction between the physician and the patient prior to the use of telemedicine to avoid conflict with some state laws. Further, there was concern regarding the aspect of informed consent and the need for credentials to be disclosed. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

(25) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 - PRESCRIBING AND DISPENSING PRESCRIPTION MEDICATION SAMPLES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 2 referred.

Council on Ethical and Judicial Affairs Report 2 describes the responsibility of dispensing samples of prescription medications to maximize benefits for patients and minimize risks and requires physicians to approach the use of samples systematically. It states that physicians will need to implement policies and practices that balance convenience, potential clinical benefits for patients, and the opportunity to enhance access to care for individual patients with the need to ensure that samples are safely managed and dispensed.

Testimony supported referral of this report. Testimony indicated confusion about the interpretation of the report as written and those testifying were greatly concerned that the report would limit their ability to dispense prescription

samples to patients. Some thought the report made dispensing prescription samples unethical. Other testimony interpreted the report to forbid prescription samples to those who could afford the full prescription, which would restrict the ability of the physician to use a prescription sample as a test trial for patients. Due to the amount of confusion in interpreting the report, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

(26) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 -
MODERNIZED CODE OF MEDICAL ETHICS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 referred.

Council on Ethical and Judicial Affairs Report 3 presents the Council's effort to consolidate, modernize, and clarify each individual Opinion in the AMA's *Code of Medical Ethics*.

Testimony focused largely on the process of how the House of Delegates has been asked to review and decide on this report. There was a lot of concern regarding the logistics of using the online forum to view the report, the inability to discuss specific changes in this Reference Committee, and the volume of the report. Several people suggested convening a special reference committee at I-15 dedicated to this report specifically. Your Reference Committee strongly agrees with this recommendation, and feels that it would give the membership a good opportunity to effectively discuss the full report, particularly since other avenues for review have not been successful. Your Reference Committee therefore recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

(27) COUNCIL ON SCIENCE AND PUBLIC HEALTH/COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - NON-MEDICAL EXEMPTIONS TO IMMUNIZATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Science and Public Health/Council on Ethical and Judicial Affairs Report 1 be referred.

HOD ACTION: Joint Council on Science and Public Health/Council on Ethical and Judicial Affairs Report 1 referred.

Council on Science and Public Health/Council on Ethical and Judicial Affairs Report 1 examines the issue of maintaining public confidence in immunizations. The report states that public confidence is critical for preventing a decline in immunization rates that can result in outbreaks of disease, and exceptions to immunizations should be limited.

Testimony for this report was strongly in favor of referral. Although some testimony agreed with the recommendations and reasoning of the report, much of the testimony stated that the report did not go far enough in closing the loophole of nonmedical immunization exemptions. Those calling for referral argued that the AMA must take a strong public health stance on this topic, and that the only way to do so is by eliminating nonmedical exemptions entirely. Your Reference Committee recommends that the Council on Science and Public Health/Council on Ethical and Judicial Affairs Report 1 be referred.

(28) RESOLUTION 16- ETHICAL PHYSICIAN CONDUCT IN THE MEDIA

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-225.994, H-445.995, H-445.997, E-5.04 and E-9.124 be reaffirmed in lieu of Resolution 16.

HOD ACTION: Resolution 16 adopted.

Resolution 16 asks that our AMA report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication. In support, this resolution cites AMA policy that requires the use of accurate medical information and the authentication of medical credentials. This resolution also asks our AMA to study disciplinary pathways for physicians that violate ethical responsibilities through their position on media platforms. Further, this resolution asks the AMA to release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence based principles and to address any conflict of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media.

Limited testimony was given on this resolution. The testimony that was provided supported the resolution, noting that the AMA should take a public stance on the medical misinformation disseminated by physicians throughout the media. However, several current AMA policies address this issue. Therefore, your Reference Committee recommends that Policies H-225.994, H-445.995, H-445.997, E-5.04 and E-9.124 be reaffirmed in lieu of Resolution 16.

H-225.994 Hospital Advertising in Printed and Broadcast Media

In order to prevent medical misinformation, the AMA encourages medical staff participation in hospital administration decisions regarding marketing and advertising.

H-445.995 Responses to News Reports and Articles

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.

H-445.997 Interviews with News Media

Our AMA: (1) recommends that, when spokesmen for medicine cooperate with the media in the production of news stories and documentaries, every effort should be made to provide media personnel with additional information and medical authentication of materials being prepared for presentation to the public; and (2) urges media personnel to seek such assistance from medical spokesmen being interviewed for their program material.

E-5.04 Communications Media: Standards of Professional Responsibility

Physicians are ethically and legally required to protect the personal privacy and other legal rights of patients. When information concerning a specific patient is requested by the media, the physician must obtain the consent of the patient or an authorized representative before releasing such information. The physician may release only the authorized information or that which is public knowledge. The patient-physician relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of the media in every way possible. When the patient or authorized representative consents to the release of information, physicians should cooperate with the press to ensure that medical news is available more promptly and more accurately than would be possible without their assistance. Inasmuch as a diagnosis may be made only by a physician and may depend upon X-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician. For the same reason, prognosis will be given only by the attending physician or at the attending physician's direction. Statements regarding the circumstances surrounding shootings, knifings, and poisonings are properly police matters, and questions whether they were accidental should be referred to the appropriate authorities. Certain news that is part of the public record, such as deaths, may be made available without the consent of the patient or authorized representative. (IV) Issued prior to April 1977; Updated June 1994 and June 1996.

E-9.124 Professionalism in the Use of Social Media

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online: (a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online. (b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate. (c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just, as they would in any other context. (d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online. (e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities. (f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV) Issued June 2011 based on the report "Professionalism in the Use of Social Media," adopted November 2010.

REPORT OF REFERENCE COMMITTEE A

(1) COUNCIL ON MEDICAL SERVICE REPORT 3 - ECONOMIC VIABILITY OF RURAL SOLE COMMUNITY HOSPITALS

RECOMMENDATION:

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

HOD ACTION: Council on Medical Service Report 3 adopted and the remainder of the report filed.

Council on Medical Service Report 3 provides background on sole community hospitals and other federally designated rural hospitals; discusses factors affecting the economic viability of small rural hospitals; highlights organizations engaged in rural hospital advocacy; and makes policy recommendations supporting the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

Testimony was supportive of Council on Medical Service Report 3. A member of the Council introduced the report and emphasized the importance of the survival and sustainability of rural health care providers, given that one quarter of the population resides in rural areas and 10 percent of physicians practice there. A representative of the New Mexico Delegation, which introduced the resolution that led to the development of Council on Medical Service Report 3, thanked the Council for its excellent work on this topic. This speaker further indicated the report will be helpful in states like New Mexico that are home to a number of sole community hospitals. Your Reference Committee concurs with the supportive testimony and recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(2) RESOLUTION 101 - INTEREST ON MEDICARE OVERPAYMENTS AND UNDERPAYMENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 101 be adopted.

HOD ACTION: Resolution 101 adopted.

Resolution 101 asks that our AMA support amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.

Testimony was limited but supportive of Resolution 101. Your Reference Committee agrees that the AMA should try to amend federal Medicare law so that interest on overpayments and underpayments to providers is assessed more equitably, and therefore recommends that Resolution 101 be adopted.

(3) RESOLUTION 108 - SURVIVORSHIP CARE PLANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 108 be adopted.

HOD ACTION: Resolution 108 adopted.

Resolution 108 Asks that our AMA support the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and support reimbursement for physician preparation of survivorship care plans for patients.

The sponsor of Resolution 108 emphasized the importance of providing survivorship care plans to patients in remission to address any related health issues that may occur in the years after they have been treated for cancer. Testimony was unanimously supportive. Your Reference Committee recommends that Resolution 108 be adopted.

(4) RESOLUTION 119 - OUT OF NETWORK COVERAGE DENIALS FOR PHYSICIAN PRESCRIPTIONS AND ORDERED SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 119 be adopted.

HOD ACTION: Resolution 119 adopted.

Resolution 119 asks that our AMA pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.

Your Reference Committee heard highly supportive testimony on Resolutions 119 and 126, both addressing the denial of coverage for medications prescribed by out-of-network physicians. Patients who privately pay for psychiatric services out-of-network and Medicaid patients who receive uncompensated care from non-Medicaid physicians could be faced with denial of their related prescriptions. Your Reference Committee notes that whether a physician is in or out of network, they still have to provide the prescription that is in the best interest of the patient within the context of the prescription coverage of the patient's plan. For these reasons, your Reference Committee supports adoption of Resolution 119.

(5) RESOLUTION 126 - OUT-OF-NETWORK RESTRICTIONS OF PHYSICIANS

RECOMMENDATION:

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

HOD ACTION: Resolution 126 adopted.

Resolution 126 asks that our AMA oppose the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.

Your Reference Committee heard highly supportive testimony on Resolutions 126 and 119, both addressing the denial of coverage for medications prescribed by out-of-network physicians. Your Reference Committee supports adoption of Resolution 126.

(6) COUNCIL ON MEDICAL SERVICE REPORT 6 - INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be amended by addition of a seventh recommendation to read as follows:

7. That our AMA promote the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 6 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 6 provides background on the movement toward integrated physical and behavioral health care; presents examples of integrated care approaches, including for children and adolescents; highlights state and specialty society activities; identifies medical and continuing education opportunities; explains payment options for integrated care; discusses barriers and potential solutions to implementing integrated care; and recommends that Medicaid and private health insurers pay for physical and behavioral health services in primary care settings on the same day, that state Medicaid programs pay for these services in school settings and that practicing physicians seek out related continuing medical education opportunities.

Supportive testimony was heard on Council on Medical Service Report 6. Many speakers commended the Council for addressing a long-standing access to care issue for individuals with coexisting physical and behavioral health care needs. Testimony shared examples of problematic situations in securing such services and expressed optimism that the recommendations in Council on Medical Service Report 6 could make a positive impact on access to comprehensive care for their patients.

An amendment was offered by the American Psychiatric Association requesting that the AMA develop sustainable reimbursement models that would be used to fund the necessary services inherent in integrating psychiatric services into primary care. Your Reference Committee agrees that the development of sustainable payment models would assist programs that currently rely on short term funding to continue providing services to their patients. While a concern was raised that Medicare does not pay for same day behavioral health care and primary care services, your Reference Committee notes that Medicare does in fact pay for the integration of these services on the same day and by the same provider.

Testimony requested that the AMA continue to study the integration of behavioral health and primary care, particularly payment mechanisms. A member of the Council on Medical Service responded to this request by stating that the Council is developing a report on team-based payment mechanisms that work in a variety of specialty practices for the 2015 Interim meeting, which could incorporate payment mechanisms for behavioral and physical health care services.

Your Reference Committee recommends that Council on Medical Service Report 6 be adopted as amended.

(7) RESOLUTION 106 - CONTROLLING THE SKYROCKETING COSTS OF
 GENERIC PRESCRIPTION DRUGS
RESOLUTION 117 - PRICING OF GENERIC DRUGS
RESOLUTION 124 - REDUCING PRESCRIPTION DRUG PRICES
RESOLUTION 125 – RISING GENERIC DRUG PRICES
RESOLUTION 127 - CONTROLLING RAPIDLY ESCALATING GENERIC
 MEDICATION PRICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 106 in lieu of Resolutions 117, 124, 125 and 127.

RESOLVED, That our American Medical Association work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the US Food and Drug Administration, the US Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs; and be it further

RESOLVED, That our AMA advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients; and be it further

RESOLVED, That our AMA encourage the development of methods that increase choice and competition in the development and pricing of generic prescription drugs; and be it further

RESOLVED, That our AMA support measures that increase price transparency for generic prescription drugs.

HOD ACTION: Substitute Resolution 106 adopted in lieu of Resolutions 117, 124, 125 and 127.

Resolution 106 asks that our AMA work collaboratively with a coalition of State Attorneys General, the United States Department of Health and Human Services, Federal Trade Commission, PhRMA, Generic Pharmaceutical Association, public and private entities, and other appropriate state and federal organizations, in an effort to find and implement, in a manner compliant with the law, alternative avenues to control the already high and escalating costs of vital generic prescription drugs. Resolution 106 also asks that our AMA support measures to increase price transparency for generic pharmaceuticals.

Resolution 117 asks that our AMA study the marketplace and regulatory changes that affect generic pricing in order to determine an advocacy position for our patients. One part of that advocacy will be to educate Congress concerning significant impact that the massive increase in the prices of generic drugs is having on the health of our patients.

Resolution 124 asks that our AMA work with Congress and other interested parties to enact legislation to insure fair and appropriate pricing, balancing access and education with competition, of critical generic medications.

Resolution 125 asks that our AMA work with interested parties including the United States Federal Trade Commission, United States Food and Drug Administration, generic drug companies, and United States Congress to explore the reasons behind increasing prices in generic drugs and possible remedies for the situation, as well as to track drug prices so that greater price transparency can help physicians prescribe lower cost drugs whenever reasonable alternatives are available.

Resolution 127 asks that our AMA advocate that when there are significant price increases that negatively impact patient access to generic medication, then the FDA may waive or reduce entry fees and expedite approval process for other manufacturers to enter the market for that medication. Resolution 127 also asks that our AMA advocate that if the production of a generic medication is shown to be a monopoly market, then the FDA may allow the importation of equivalent medication from selected manufacturers abroad.

Testimony regarding the aforementioned resolutions was passionate and predominantly supportive of the AMA taking action to address generic prescription drug price increases. Several speakers highlighted specific generics whose prices have recently surged, and further described the detrimental effects that these price increases have on patients, some of whom choose to forego taking medications due to their high cost. Speakers also testified that generic prescription drug price increases may result from different factors, including consolidation among generic manufacturers, drug shortages, and a lack of competition in the generics market.

A member of the Council on Medical Service spoke of his personal experiences with patients whose generic medications now cost more than their brand name counterparts. The Council suggested referral of Resolutions 106, 117, 124, 125 and 127 because the Council is currently working on a report on pharmaceutical costs that examines both brand name and generic prescription drug price increases. It was further noted that this Council report will be presented to the House of Delegates at the 2015 Interim Meeting. A member of the Council on Legislation also asked that these resolutions be referred.

Some testimony at the hearing supported referral. However, a majority of speakers spoke in support of the resolutions instead of referral due to the urgency of the topic. A handful of speakers specifically asked your Reference Committee to develop policy at this meeting instead of waiting until the Interim Meeting for the Council on Medical Service's pharmaceutical pricing report.

Your Reference Committee points out that AMA policy supports a market-based approach to pharmaceutical pricing but also supports legislation that gives the Secretary of Health and Human Services the authority to negotiate contracts with manufacturers of covered Medicare Part D drugs. Your Reference Committee appreciates the work of the Council on Medical Service on this topic and looks forward to its report at the Interim Meeting. Your Reference Committee believes that the testimony and the fact that five resolutions addressing generic prescription drug costs were submitted for consideration speak to the urgency of these issues. Your Reference Committee recommends adoption of Substitute Resolution 106.

(8) **RESOLUTION 128 - INCLUDE PHYSICIANS IN CMS RATE INCREASES TO MEDICARE ADVANTAGE PLANS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 128.

RESOLVED, That our AMA encourage Medicare Advantage plans to be transparent with respect to the allocation of their rate increases; and be it further

RESOLVED, That our AMA encourage individual physicians to negotiate rate increases that parallel or improve upon the percentage increases received by the Medicare Advantage plans with which they contract.

HOD ACTION: Substitute Resolution 128 adopted.

Resolution 128 asks that our AMA strongly encourage CMS to require that whenever Medicare Advantage (MA) plans get an increase in their rates, that the MA plans provide an equivalent percentage increase in their contracted rates for physicians.

Testimony on Resolution 128 was mixed. A member of the Council on Legislation testified that the Centers for Medicare and Medicaid Services does not have the authority to dictate the payment dispersal methods of Medicare Advantage plans, and that federal or state legislation to accomplish a dispersal that provides a parallel percentage increase for physicians is not feasible.

Your Reference Committee heard testimony cautioning against tying physician rates to those of MA plans, since MA rates could go down. In addition, your Reference Committee also notes there is no law against MA plans providing more than the Medicare rate. As your Reference Committee considered how to ensure physicians receive increased contract rates when MA plans receive increases in their rates, it determined that physicians would need to know what increases the MA plans received and have contract language that requires them to receive an equivalent or greater percentage increase in their contracted rates. Accordingly, your Reference Committee offers Substitute Resolution 128 for consideration.

(9) **RESOLUTION 121 - FLEXIBLE SPENDING ACCOUNT AMOUNTS**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 121 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate for a reasonable increase in Section 125 Flex Spending accounts ~~to a level sufficient to meet patients' typical out-of-pocket expenses.~~

RECOMMENDATION B:

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

HOD ACTION: Resolution 121 adopted as amended.

Resolution 121 asks that our AMA advocate for a reasonable increase in Section 125 Flex Spending accounts to a level sufficient to meet patients' typical out-of-pocket expenses.

Your Reference Committee heard limited testimony that indicated confusion about the difference between flexible spending accounts (FSAs) and health savings accounts (HSAs). Your Reference Committee notes that FSAs, as stated in Resolution 121, were limited to \$2500 annually by the Affordable Care Act (ACA). FSAs have always been and continue to be "use it or lose it" accounts that generally are forfeited if not used in the year for which pre-tax dollars were contributed. AMA Policy H-165.863 supports allowing employees to roll-over any unexpended funds in a FSA into an HSA. Prior to the ACA, the IRS imposed no limits on FSAs, although employers did.

In contrast with FSAs, the contribution amounts on HSAs were not impacted by the ACA. Also unlike FSAs, HSAs can roll-over from year to year. Unused HSA contributions can be accumulated and invested. In 2015, the contribution limits for HSAs are \$3350 for individuals and \$6550 for families. In addition, those aged 55 and older can make catch-up contributions of \$1000 annually. Contributions to an HSA can lower modified adjusted gross income, lower one's tax bracket, and allow out-of-pocket costs to be paid tax-free, a stated goal of Resolution 121. Policy H-165.852 advocates that HSAs be used for meeting deductibles.

Your Reference Committee applauds the sponsor for raising concern about the affordability of high deductible health plans and believes that allowing more pre-tax contributions to FSAs merits adoption. However, your Reference Committee notes that allowing FSA contributions to rise to "a level sufficient to meet patients' typical out-of-pocket expenses" could expose patients to too great a risk of forfeiture of unspent FSA funds. Accordingly, your Reference Committee recommends amending Resolution 121 by deletion as indicated.

(10) RESOLUTION 116 - STUDY THE IMPACT OF THE ACA MEDICAID EXPANSION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 116 be amended by deletion on page 2, lines 4-6, to read as follows:

RESOLVED, That our American Medical Association use all available data to study the issues surrounding the expansion of Medicaid to tens of millions of low-income adults as specified by the Affordable Care Act to evaluate to the best extent possible (a) the level of health care access available to those who are part of the Medicaid expansion population ~~as opposed to those who are otherwise insured,~~ (b) the quality of health care services provided to those who are part of the Medicaid expansion population ~~as opposed to those who are otherwise insured,~~ (c) the adequacy of provider payments for the services rendered to those in the Medicaid expansion population, and (d) the ramifications of the ACA's Medicaid expansion to the health care system as a

whole, including but not limited to the possibilities of increased health care cost-shifting and increased emergency room use; and be it further

RECOMMENDATION B:

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

HOD ACTION: Resolution 116 adopted as amended.

Resolution 116 asks that our AMA use all available data to study the issues surrounding the expansion of Medicaid to tens of millions of low-income adults as specified by the Affordable Care Act to evaluate to the best extent possible (a) the level of health care access available to those who are part of the Medicaid expansion population as opposed to those who are otherwise insured, (b) the quality of health care services provided to those who are part of the Medicaid expansion population as opposed to those who are otherwise insured, (c) the adequacy of provider payments for the services rendered to those in the Medicaid expansion population, and (d) the ramifications of the ACA's Medicaid expansion to the health care system as a whole, including but not limited to the possibilities of increased health care cost-shifting and increased emergency room use.

Supportive testimony was heard on Resolution 116. A few speakers cautioned that outcomes from a study on issues surrounding the expansion of Medicaid as compared to "those who are otherwise insured" may not be the sole comparison. Such a study may result in an inaccurate impression of the provision of care for Medicaid patients. Your Reference Committee recommends that a broader study on the progress of the program would provide more meaningful data. As such, your Reference Committee recommends deleting the language "as opposed to those who are otherwise insured" on lines 4, 5 and 6 of the first Resolve clause.

(11) RESOLUTION 107 - REIMBURSEMENT FOR END-OF-LIFE COUNSELING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-390.916 be amended by addition and deletion to read as follows:

H-390.916 Payment for Patient Conferences Counseling Regarding Advance Care Planning Directives (under Medicare)

That our AMA encourage all public and private health insurers to be required to pay, at a reasonable payment rate, for counseling payment for medical conferences with patients and/or relatives and guardians regarding medical management and future medical management, advance care planning, including goals of care, as an accepted and integral part of good medical care, particularly as it relates to the discussion of advance directives (i.e., e.g., living wills and durable powers of attorney for health care). (Res. 1, I-90; Reaffirmed: Sunset Report, I-00; Modified in lieu of Res. 101, A-07; Reaffirmation A-09)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-390.916 be adopted in lieu of Resolution 107.

HOD ACTION: Amended Policy H-390.916 adopted in lieu of Resolution 107.

Resolution 107 asks that our AMA urge all public and private health insurers to be required to cover, at a reasonable reimbursement rate, counseling for end-of-life care planning as an accepted and integral part of good medical care.

The sponsors of Resolution 107 expressed the need for better care and counseling regarding end-of-life care and end-of-life counseling. Testimony was supportive of providing these services to individuals across the lifespan. Additional testimony identified existing AMA Policy H-390.916, which supports payment for patient conferences regarding advance directives under Medicare. Your Reference Committee suggests amending Policy H-390.916 to include the language on private health insurers from Resolution 107 to address the sponsor's intent. Several speakers also suggested replacing the language "end-of-life" with "advance care planning" to be consistent with CPT code language.

(12) RESOLUTION 111 - EVALUATE VOUCHERS PROGRAM FOR VETERANS TO PURCHASE PRIVATE HEALTH INSURANCE
 RESOLUTION 112 – IMPROVING TIMELY ACCESS TO QUALITY HEALTHCARE FOR AMERICA'S VETERANS
 RESOLUTION 114 - AN HSA CARD WILL GIVE VETERANS BETTER, FASTER HEALTH CARE
 RESOLUTION 130 – ENSURING ENHANCED DELIVERY OF HEALTH CARE TO OUR NATION'S VETERANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 111 in lieu of Resolutions 112, 114 and 130.

ACCESS TO HEALTH CARE FOR VETERANS

RESOLVED, That our AMA continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; and be it further

RESOLVED, That our AMA monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; and be it further

RESOLVED, That our AMA call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; and be it further

RESOLVED, That our AMA advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; and be it further

RESOLVED, That our AMA advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and be it further

RESOLVED, That our AMA support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

HOD ACTION: Substitute Resolution 111 adopted in lieu of Resolutions 112, 114 and 130.

Resolution 111 asks that our AMA investigate the utility and benefit of a voucher program for veterans to purchase private health insurance for access to care outside the Veterans Administration and report back on its findings at the 2015 Interim Meeting.

Resolution 112 asks that our AMA seek federal legislation to amend the Veterans Access, Choice, and Accountability Act of 2014 to provide that: (1) private physicians be offered contracts for reimbursement at no less than the current Medicare allowable rates for all visits and approved procedures and (2) the Veterans Administration will be directed to hire additional physicians, both full and part time and both primary and specialty physicians as needed to provide timely care to America's Veterans. Resolution 112 also asks that our AMA attempt to work directly with the Veterans Administration to improve timely access to care for America's Veterans by obtaining reimbursement for private physicians at current Medicare Allowable rates for visits and approved procedures until such time as the Veterans Healthcare System can consistently provide this service.

Resolution 114 asks that our AMA call for a study of the Veterans Affairs system to address access to care issues experienced by veterans and urge use of alternatives, such as a debit card that would allow veterans the freedom to access care from a doctor of their choice.

Resolution 130 asks that our AMA continue its strong advocacy for safe, timely, and effective healthcare for all patients, including our nation's veterans; and that as part of its commitment to safe, timely, and effective health care for all patients, our AMA support, encourage, and assist in any way possible all organizations, including but not limited to the Veterans Administration, the Department of Justice, the Office of the Inspector General, and The Joint Commission, to ensure enhanced delivery of health care to our nation's veterans.

Extensive testimony was heard on Resolutions 111, 112, 114, and 130. Your Reference Committee recognizes that the volume of resolutions and passionate testimony on access to care for veterans reflects a need for improvement in the Veterans Administration health care system. Testimony stated that the AMA is and will continue to be in communication with the VA to improve health care to veterans both within and outside of the VA health system.

Some speakers testified in favor of alternatives to the Veterans Choice Program's "Choice Card" so veterans can more efficiently access health care outside of the VA health system. Other testimony recognized that the Choice Card has only been in effect since last November and felt it was premature to consider alternatives, such as a voucher or debit card, when AMA advocacy efforts are making a positive impact on the program. For example, the AMA sent a letter to the VA in March urging it to change the way it calculates the 40 mile distance criteria from a straight-line to the time that it takes for a veteran to travel to the nearest VA medical facility. This advocacy was instrumental in influencing the VA to make this change in April.

In response to testimony urging the AMA to study the VA health system, some speakers stated that the Government Accountability Office and the Veterans of Foreign Wars are assessing veterans' access to health care and providing recommendations to the VA. Your Reference Committee believes that these organizations are the appropriate entities to review the VA health system. Your Reference Committee believes it would be more appropriate for the AMA to support, encourage and assist appropriate organizations to ensure comprehensive delivery of care for veterans.

Testimony also expressed concerns about the lack of both primary and specialty physicians in the VA system as well as inadequate payment. Your Reference Committee took into consideration the issues raised in testimony and has provided substitute language incorporating all concerns.

(13) RESOLUTION 115 - SUPPORT FOR INCLUSION OF VASECTOMY IN THE ACA PREVENTIVE SERVICES AND CONTRACEPTIVE MANDATE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 115.

RESOLVED, That our AMA work in concert with national specialty and state medical societies to advocate for patient access to the full continuum of

evidence-based contraceptive methods and sterilization procedures, including vasectomy and male contraceptive counseling, to promote gender equity in contraceptive services under the ACA.

HOD ACTION: Substitute Resolution 115 adopted.

Resolution 115 asks that our AMA support amendment of the list of preventive services defined by the Department of Health and Human Services to include male sterilization and male contraception counseling and to advocate for the U.S. Preventive Services Task Force to review the evidence and provide recommendations for preventive services to include all appropriate contraceptive services for patients, regardless of gender, including vasectomies.

Amended language was offered by the sponsor of Resolution 115 in an attempt to simplify the resolution. A member of the Council on Medical Service testified that AMA policy (Policies H-185.964 and H-165.856) generally opposes new benefit mandates. The Council member further suggested alternative language which is comparable to policies adopted on other health benefits that asks the AMA to advocate for patient access to the full continuum of evidence-based contraceptive methods and sterilization procedures, including vasectomy and male contraceptive counseling. Testimony was supportive of patient access to the full continuum of evidence-based procedures, including vasectomy, which is efficacious and cost-effective as compared to tubal ligation. Your Reference Committee concurs with this testimony and recommends adoption of Substitute Resolution 115.

(14) RESOLUTION 129 - MOVING TO ALTERNATIVE PAYMENT MODELS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 129 be amended by deletion of the first Resolve on page 2, lines 1-3.

~~RESOLVED, That our American Medical Association support accelerated movement of physician payment to pay for value in accordance with its Pay for Performance Principles and Guidelines (Policy H-450.947).~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 129 be amended by addition on page 2, line 13, to read as follows:

~~RESOLVED, That, as physician payment moves to pay-for-value, our AMA will help physician practices with the following:~~

- Physician practices need support and guidance to optimize the quantity and content of physician work under alternative payment models;
- Address physicians' concerns about the operational details of alternative payment models to improve their effectiveness;
- To succeed in alternative payment models, physician practices need data and resources for data management and analysis;
- Harmonize key components of alternative payment models across multiple payers, especially performance measures to help physician practices respond constructively; and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 129 be adopted as amended.

HOD ACTION: Resolution 129 adopted as amended.

Resolution 129 asks the AMA to support accelerated movement of physician payment to pay-for-value in accordance with its Pay-for-Performance Principles and Guidelines (H-450.947).

Resolution 129 also asks that as physician payment moves to pay-for-value, our AMA will help physician practices with the following:

- Physician practices need support and guidance to optimize the quantity and content of physician work under alternative payment models;
- Address physicians' concerns about the operational details of alternative payment models to improve their effectiveness;
- To succeed in alternative payment models, physician practices need data and resources for data management and analysis;
- Harmonize key components of alternative payment models, especially performance measures to help physician practices respond constructively; and be it further

Resolution 129 also asks the AMA, in partnership with other appropriate physician organizations, to work with the Centers for Medicare & Medicaid Services to establish an appropriate timetable for implementation of pay-for-value models that takes into account the physician community's readiness to assume two-sided risk (up-side and down-side risk).

Your Reference Committee heard contentious testimony on Resolution 129. The sponsor stated that the intent of the resolution was to request the AMA to assist physicians in moving toward value-based payment models. Testimony expressed strong sentiments in opposition to the first Resolve as it supports an acceleration toward value-based payment that numerous speakers expressed was not feasible at this time. Many speakers stated the importance of maintaining pluralism for various payment options. Additional testimony was in support of the second and third Resolves, although your Reference Committee felt that a minor clarification was needed to include language on "multiple payers" in the second Resolve.

(15) RESOLUTION 103 - THREE DAY STAY RULE
 RESOLUTION 105 - EXPANDING MEDICARE'S THREE-DAY HOSPITAL STAY REQUIREMENT TO INCLUDE OBSERVATION HOURS
 RESOLUTION 110 - REMOVAL OF THE REQUIRED THREE DAY STAY FOR PLACEMENT INTO SKILLED OR LONG-TERM CARE FACILITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 103 in lieu of Resolutions 105 and 110.

RESOLVED, That our American Medical Association continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients; and be it further

RESOLVED, That our AMA continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency ~~room~~ department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services.

HOD ACTION: Substitute Resolution 103 adopted as amended in lieu of Resolution 105. First resolve of Resolution 110 also adopted.

Resolution 103 asks that our AMA adopt as policy, the goal of eliminating Medicare's requirement of a hospital inpatient admission of three days as a condition of eligibility for receiving post hospital Medicare rehab and nursing benefits.

Resolution 105 asks that our AMA work aggressively with the Congress and the Centers for Medicare & Medicaid Services to expand Medicare's prerequisite three-day hospital stay cumulative time for Medicare coverage of skilled nursing facility care to include hospital time known as observational stay/hours.

Resolution 110 asks that our AMA work with CMS to eliminate regulations requiring inpatient hospitalization as a prerequisite for SNF care. Resolution 110 also asks that our AMA oppose CMS regulations that do not apply equally to all physicians/physician groups who provide care to Medicare patients.

Testimony acknowledged that the AMA has policy calling for elimination of Medicare's three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services (Policies H-280.950, D-280.988 and H-280.977). Your Reference Committee appreciates the sentiment of the many speakers who testified in support of these resolutions and against reaffirmation, which was recommended by representatives of both the Council on Medical Service and the Council on Legislation. A member of the Council on Medical Service also noted that a two-page document explaining inpatient versus observation care is available on the Council's Web page (www.ama-assn.org/go/cms). Your Reference Committee acknowledges the AMA's advocacy efforts to eliminate the three-day stay requirement and also to count patient time spent in hospital observation care toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services.

Several speakers expressed frustration that existing policy on the three-day inpatient hospital stay requirement has not led to its elimination. It was noted that, many years ago, the requirement was appropriate because patients needed to be stabilized in the hospital setting before going to a skilled nursing facility. Your Reference Committee agrees that inpatient hospital stays are no longer necessary prior to the provision of skilled nursing facility care, and that the requirement results in many patients being hospitalized unnecessarily. Testimony also noted that the Centers for Medicare & Medicaid Services waived the three-day inpatient stay requirement for Tier 3 participants in its Next Generation ACO Model.

Your Reference Committee concurs with testimony highlighting the importance of eliminating the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. Furthermore, your Reference Committee concurs that the AMA should continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in hospital observation care or in the emergency room count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. Your Reference Committee therefore recommends adoption of Substitute Resolution 103 in lieu of Resolutions 103, 105 and 110.

(16) RESOLUTION 120 - HIGH DEDUCTIBLE, HIGH COINSURANCE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be referred.

HOD ACTION: Resolution 120 referred.

Resolution 120 asks that our AMA study how high deductible, high maximum out of pocket insurance policies affect health care costs in the immediate and distant future so that we may learn whether this actually increases total cost of care over time by delaying early treatment and secondary prevention efforts.

Testimony was generally favorable of studying high deductible and high out-of-pocket insurance policies. In particular, there was concern that although the Affordable Care Act provides (ACA) for an array of preventive screenings for chronic conditions, some health plans provide no coverage for the ongoing treatment of chronic conditions. Accordingly, testimony concluded, physicians will see more advanced disease in patients once patients do seek treatment. Testimony favored including pediatric concerns in any study of high-deductible health plans.

Other testimony encouraged any study of high deductible health plans to consider ways to mitigate the cost of such plans by using health savings accounts (HSAs). The Council on Medical Service concurred with testimony that the requested study is premature, since high deductible plans for low-income patients proliferated under the ACA just in the last year. The Council also indicated that it is studying affordability for an I-15 report on modernizing AMA health system reform policies. Accordingly, the Council requested referral and your Reference Committee agrees with the recommendation to refer.

(17) RESOLUTION 122 - CHRONIC DISEASES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-185.939 and H-155.960 be reaffirmed in lieu of Resolution 122.

HOD ACTION: Policies H-185.939 and H-155.960 reaffirmed in lieu of Resolution 122.

Resolution 122 asks that our AMA study the concept of having insurance policies include a specified number of no deductible, no co-insurance visits for the treatment of specific chronic diseases where there is good evidence that early treatment is effective in reducing disease burden in the population and where delayed treatment will have public health consequences for the population and potentially increase total health care costs by delaying opportunities for early treatment or secondary prevention.

Testimony was limited and generally favored reaffirmation of AMA policy on value-based and targeted benefit design. There was concern about whether the AMA could specify which chronic conditions would receive coverage without cost-sharing. The Council on Medical Service testified that its Report 2-A-13, adopted by the House, established policy on value-based insurance design, which can lower cost-sharing for chronic diseases where there is strong evidence that early treatment and adherence improves value. Consistently, an earlier Council on Medical Service Report 8-A-07 established Policy H-155.960, which encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. The policy goes on to state that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance.

Your Reference Committee concurs with the sentiment of testimony and the reaffirmation recommendation of the Committee on Rules and Credentials, and recommends reaffirmation of Policies H-185.939 and H-155.960.

H-185.939 Value-Based Insurance Design

Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles: a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements. b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists. c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan. d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients. e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design. f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties. h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence. i. VBID programs must be consistent with AMA Pay for

Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972). (CMS Rep. 2, A-13)

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 determined based on the clinical value of a health care service or treatment. Consideration should be given to further 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. (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system. (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; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13)

REFERENCE COMMITTEE B

(1) BOARD OF TRUSTEES REPORT 8 - OPPOSITION TO LABORATORY REPORTING PROVISIONS OF HR 4302

RECOMMENDATION:

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

HOD ACTION: Recommendation in Board of Trustees Report 8 adopted and the remainder of the report filed.

AMA Board of Trustees Report 8 recommends that our American Medical Association work with Federation members and other major stakeholders, including the clinical laboratory and hospital associations, to identify and pursue viable congressional and regulatory strategies to eliminate or substantially reduce the reporting burden associated with Medicare rate setting for laboratory fee schedule services and procedures while supporting access to clinical laboratory services among the spectrum of providers of these services.

Your Reference Committee heard limited but supportive testimony on Board Report 8. Testimony noted that the report recommends a strategic approach with greater stakeholder involvement to eliminate or substantially reduce the reporting burden associated with Medicare rate setting for laboratory fee schedule services and procedures. A representative from our AMA Council on Legislation testified that, since H.R. 4302 was passed, our AMA has been in ongoing discussions with the American Clinical Laboratory Association and communicated to the Centers for Medicare & Medicaid Services our concerns that the new method of calculating payment for laboratory testing services will be highly burdensome. Accordingly, your Reference Committee agrees with the support of this report and recommends adoption of its recommendation.

(2) BOARD OF TRUSTEES REPORT 15 - OVER THE COUNTER (OTC) INSULIN

RECOMMENDATION:

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

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

AMA Board of Trustees Report 15 recommends that Resolution 507-A-14 not be adopted and the remainder of the report be filed.

Your Reference Committee heard mixed testimony regarding the recommendation in Board of Trustees Report 15. Those in support of adopting the recommendation on the report noted that the original Resolution 507-A-14 did not consider the link between the availability of over the counter (OTC) insulin and patient access to care. Others who testified in support of adopting the original Resolution 507-A-14 expressed concern over the risk of over-the-counter insulin. Your Reference Committee believes the report addresses these concerns and why the original resolution may have negative effects if it were adopted. Your Reference Committee therefore recommends adoption of the recommendation of Board Report 15 and that the remainder of the report be filed.

(3) RESOLUTION 221 - QUALITY IMPROVEMENT IN CLINICAL/POPULATION HEALTH INFORMATION SYSTEMS

RECOMMENDATION:

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

HOD ACTION: Resolution 221 adopted.

Resolution 221 asks that our American Medical Association invite other expert physician associations into the AMA consortium to further the quality improvement of Electronic Health Records (EHRs) and population health as discussed in the consortium letter of January 21, 2015 to the National Coordinator of Health Information Technology.

Your Reference Committee heard limited but supportive testimony with respect to Resolution 221. Testimony noted that our AMA has engaged with the additional stakeholders identified in the Resolution regarding ways to improve EHRs and is seeking a broad coalition to address and resolve problems with the Meaningful Use program. Given that ongoing AMA advocacy is seeking to fulfill the purpose of this Resolution, your Reference Committee recommends adoption of Resolution 221.

(4) RESOLUTION 230 - OPPOSING LINKING ABMS CERTIFICATION TO
INTERSTATE LICENSURE AND TELEMEDICINE
RESOLUTION 231 - OPPOSING THE FEDERATION OF STATE MEDICAL
BOARDS INTERSTATE MEDICAL LICENSURE COMPACT
RESOLUTION 235 - MOC PROVISIONS OF INTERSTATE MEDICAL
LICENSURE COMPACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 235 be adopted in lieu of Resolutions 230 and 231.

HOD ACTION: Resolution 235 adopted in lieu of Resolutions 230 and 231.

Resolution 230 asks that our American Medical Association work with the Federation of State Medical Boards (FSMB) to amend the definition of “physician” contained in the Interstate Medical Licensure Compact by deleting the provision that requires a “physician” to hold “specialty certification or a time-limited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association’s Bureau of Osteopathic Specialists” and oppose the linkage of state or interstate licensure for telemedicine to Maintenance of Certification. Resolution 231 asks that our American Medical Association amend Policy D-275.994 by addition and deletion to read that our AMA oppose, rather than support, the FSMB Interstate Compact for Medical Licensure. Resolution 235 asks that our American Medical Association, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician “holds” specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association’s (AOA’s) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS’s Maintenance of Certification or AOA’s Osteopathic Continuous Certification (OCC) program in order to receive initial or continued licensure under the Interstate Medical Licensure Compact.

Your Reference Committee heard testimony generally in favor of adoption of Resolution 235 in lieu of Resolutions 230 and 231. In particular, testimony from those states that have joined the Compact to date spoke favorably of the Compact’s potential to help expedite physician licensure, address physician shortages, and promote physicians’ ability to move between states. Such testimony urged our AMA to support the Compact and other systems that might improve the current system of medical licensure.

Your Reference Committee heard general support for the request for a clarifying statement sought by Resolution 235, in particular, instead of a more onerous process that might require each state that has adopted the Compact to revalidate legislation. Testimony noted that the Compact does not require or make mention of Maintenance of Certification (MOC) or Osteopathic Continuous Certification (OCC), at any stage of participation. Testimony recognized that board certification is one of nine eligibility requirements as an entry point into the Compact

expedited licensing process. Once a physician is issued a license via the Compact process, the physician must comply with all of the existing rules and regulations, including renewal processes and Continuing Medical Education (CME) requirements, of the respective states where the physician is licensed.

Testimony also clarified that board certification was included as an initial eligibility factor because, in order for the Compact to be acceptable in all U.S. states and territories, the definition of physician had to be drafted in a manner that meets the highest standards required for expedited licensure, including several states that already have standards in place for expedited licensure that include such factors as specialty-board certification. Your Reference Committee heard that an estimated 80 percent of U.S. physicians are eligible to participate in the Compact, if they choose to do so, as the Compact process is entirely voluntary for physicians, who will still be able to seek licensure on a state-by-state basis, regardless of their Compact eligibility status. Testimony also suggested that board certification is one method of verifying proper clinical and surgical skills, knowledge, and core competencies during residency training, and as such, a medical board issuing an “expedited” license via the Compact can have some assurance that the physician was properly trained and has the qualifications necessary to have Board Certification without having to verify these independently, which often significantly slows down the licensing process.

Your Reference Committee particularly heard testimony that AMA opposition to the Compact could have a detrimental effect on our federal efforts to stop the movement of legislation that would federalize physician licensure or change in licensure to the state where the physician rather than the patient is located. Testimony suggested that the Compact will not supersede a state’s autonomy and control over the practice of medicine, but rather is an expression of state authority, as states will maintain control through a coordinated legislative and administrative process. Your Reference Committee heard that the Compact is a key element to thwarting the ongoing efforts of several federal policymakers and powerful interest groups that seek to nationalize the medical licensure system. For these reasons, your Reference Committee recommends that Resolution 235 be adopted in lieu of Resolutions 230 and 231.

(5) RESOLUTION 232 - CHILD-RESISTANT CAPS ON ENERGY DRINKS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 232 be adopted.

HOD ACTION: Resolution 232 adopted.

Resolution 232 asks that our American Medical Association urge that the US Food and Drug Administration and/or US Congress take legislative or regulatory action on the federal level to require child-resistant packaging on all high energy drinks manufactured in the United States.

Your Reference Committee heard limited testimony in support of Resolution 232 on the dangers to young children of energy drink exposure. Testimony was presented that requiring child-resistant packaging on all high energy drinks manufactured in the U.S. would help protect children from exposure to the dangerous energy drinks. Testimony was also presented that existing AMA policy already directs our AMA to seek necessary regulatory action through the FDA to regulate potentially hazardous energy beverages. Your Reference Committee agrees that children should be protected from energy drink exposure and accordingly recommends adoption of Resolution 232.

(6) RESOLUTION 234 - PRESERVING FREE SPEECH AND CONFIDENTIALITY IN THE PHYSICIAN-PATIENT RELATIONSHIP

RECOMMENDATION:

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

HOD ACTION: Resolution 234 adopted.

Resolution 234 asks that our American Medical Association strongly oppose any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Your Reference Committee heard testimony urging our AMA to maintain its vigilance in protecting the sanctity of the patient-physician relationship. Your Reference Committee is deeply concerned with the increasing prevalence of third-party intrusions into this relationship and, as such, commends our AMA for organizing a coalition of several national specialty medical societies as *amici*, writing and filing an *amicus* brief in the Eleventh Circuit in support of the physician plaintiffs as part of the initial appeal and writing and filing an *amicus* brief in support of the petition for rehearing in *Wollschlaeger v. State of Florida* (<http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/litigation-center/case-summaries-topic/physician-patient-communications.page>). (Notably, at issue in this case is whether state law that restricts physicians' communications regarding their patients' firearm ownership violates the First Amendment.) Your Reference Committee also applauds our AMA for creating a state-based advocacy campaign entitled, "Keeping politics out of the exam room: Protecting the patient-physician relationship" (www.ama-assn.org/go/arc, see public health campaign) and for working with state and national medical specialties to either enact AMA model legislation prohibiting the criminalization of health care decision-making and/or defeat attempts by third parties to prescribe or proscribe the content of information exchanged between physicians and their patients. At the state level these forays into the practice of medicine not only infringe on physicians' First Amendment right to free speech, they potentially place physicians in an untenable position of risking disciplinary proceedings, criminal prosecution or abandoning ethical obligations to foster patient autonomy. More important than all of these considerations, however, is the real harm that may come to patients if these laws continue to interfere with their ability to have access to the most current medical information available. The patient-physician relationship is the cornerstone of the practice of medicine and, as such, your Reference Committee urges adoption of Resolution 234.

(7) BOARD OF TRUSTEES REPORT 6 - MEDICAL INFORMATION AND ITS USES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Recommendation in page 6, line 27 of Board of Trustees Report 6 be amended by addition and deletion to read as follows:

Our AMA seeks to ~~improve the quality of patient care and help physicians~~ ~~improve the quality reporting of patient care data and adapt to promote~~ new payment and delivery models to transform our health care system.

RECOMMENDATION B:

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

HOD ACTION: Recommendations in Board of Trustees Report 6 adopted as amended and the remainder of the report filed.

Board of Trustees Report 6 recommends that our American Medical Association adopt as new policy the following Data Transparency Principles to Promote Improvements in Quality and Care Delivery.

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to improve the quality of patient care and promote new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable

health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians – Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models – Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions – Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians – Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients – Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers – Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability – Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data – While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data – Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data – Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility – Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization – Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden – To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution – Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

Your Reference Committee heard testimony in support of Board of Trustees Report 6, which offers data transparency principles to promote improvements in quality and care delivery. Testimony in favor of this report stated that greater transparency with respect to quality and cost could help provide needed information to physicians and enable new delivery and payment models. A friendly amendment was offered to revise the first recommendation to highlight that the focus of the report is to improve the quality of the reporting. Other testimony noted that the intent of the original resolution that spurred this report was to focus on the commercial value of data. Your Reference Committee, however, notes that Council on Medical Service Report 4 on price transparency, which is being considered at this Annual Meeting, covers and speaks to this issue. Your Reference Committee agrees with this testimony, including the offered amendment, and believes this report builds upon existing AMA policies that address safeguards for the release of physician claims data and allows our AMA to further improve existing transparency efforts. In light of these views, your Reference Committee recommends that the recommendations of Board Report 6 be amended and the remainder of the Report be filed.

(8) **BOARD OF TRUSTEES REPORT 10 - COUNCIL ON LEGISLATION
SUNSET REVIEW OF 2005 HOUSE POLICIES**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 10 be amended by addition to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, with the exception of Directive D-090.994 that should be retained.

RECOMMENDATION B:

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

HOD ACTION: Recommendation in Board of Trustees Report 10 adopted as amended and the remainder of the report filed.

Board of Trustees Report 10 recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard testimony that the recommendation in Board of Trustees Report 10 related to Directive D-090.994 should be changed from rescind to retain, with an amendment to remove the reference to the Private Sector Advocacy Group. Your reference Committee agrees and recommends that Directive D-090.994 be amended to read: “Our AMA encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact our AMA for assistance. Our AMA will post a notice on its web site, informing physicians how to report such incidents.”

(9) BOARD OF TRUSTEES REPORT 12 - DEVELOPMENT AND PROMOTION OF SINGLE NATIONAL PRESCRIPTION DRUG MONITORING PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be amended by addition of a new recommendation 7 to read as follows:

7. That our AMA encourage states to share access to PDMP data across state lines, within the safeguards applicable to protected health information.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be amended by addition of a new recommendation 8 to read as follows:

8. That our AMA encourage state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

RECOMMENDATION C:

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

HOD ACTION: Recommendations in Board of Trustees Report 12 adopted as amended and the remainder of the report filed.

The Board of Trustees Report 12 recommends the following:

1. That our AMA reaffirm Policy H-95.945, "Prescription Drug Diversion, Misuse and Addiction," Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality," Policy H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances," and Policy H-95.990, "Drug Abuse Related to Prescribing Practices."
2. That our AMA support the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate;
3. That our AMA encourage states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care;
4. That our AMA support the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law;
5. That our AMA encourage states to foster increased PDMP use through a seamless registration process; and
6. That our AMA encourage all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management.

Your Reference Committee heard testimony in support of Board of Trustees Report 12 that addresses the nation's prescription drug abuse, misuse, overdose and death epidemic that continues to affect tens of thousands of Americans. Many policymakers and others claim that a mandated, national prescription drug monitoring program (PDMPs) would solve this national epidemic. Testimony in agreement with the report noted that on the one hand, PDMPs—when fully funded, modernized, and available at the point of care—can provide useful clinical

information, including information that might indicate aberrant prescription drug use. On the other hand, most state PDMPs are not modernized or able to provide this functionality, but most states are investing heavily to improve state-based PDMPs. An amendment was offered to add a resolve that would encourage states to share access to PDMP data across state lines. Testimony for this amendment was largely favorable. An additional amendment was offered to add a recommendation that would encourage state PDMPs to adopt uniform data standards to facilitate sharing of information across state lines. Testimony for this amendment was also largely favorable. Your Reference Committee also notes that some states have already adopted such standards in the interest of interoperability.

In light of these views, your Reference Committee believes the report's recommendations are designed to further encourage physicians to use PDMPs and provide a set of policy recommendations that have been supported in the states. Your Reference Committee also supports the suggested amendments. Therefore, your Reference Committee recommends that the recommendations of Board of Trustees Report 12 be adopted as amended and the remainder of the report be filed.

(10) **BOARD OF TRUSTEES REPORT 19 - LIABILITY RELATED TO
REFERRALS FROM FREE CLINICS**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 19 be amended by addition and deletion to read as follows:

That our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care in hospitals, offices, clinics or other health care settings at their offices or clinics to patients referred from free clinics.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 19 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 19 adopted as amended and the remainder of the report filed.

Board of Trustees Report 19 recommends that our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care at their offices or clinics to patients referred from free clinics.

Your Reference Committee received testimony in support of Board of Trustees Report 19. Those testifying noted the importance of ensuring the availability of charity care for patients. Testimony offered an amendment to reflect the referred care can be provided in a broad array of settings, beyond offices and clinics. Other testimony suggested that the recommendation be made even broader to simply enact liability immunity for all charity care. With respect to this later amendment, existing AMA Policy H-435.976 already supports broad liability protection for physicians who volunteer their services and deliver pro bono care. Rather, this report sought to address a specific issue on how to expand the FTCA to referral entities and wants to be clear that we are not duplicating existing AMA policy. Your Reference Committee believes that extending these liability protections to referred physicians will allow patients to obtain more comprehensive care and follow-up regarding their medical needs. Your Reference Committee, therefore, recommends amendment of the recommendation in Board of Trustees Report 19 and that the remainder of the report be filed.

(11) **BOARD OF TRUSTEES REPORT 26 - UNCOUPLING OF CPT FROM
ICD-10**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of a Substitute Recommendation for Board Report 26 and that the remainder of the report be filed:

The Board of Trustees recommends that the Comptroller General of the Government Accountability Office not address uncoupling the ICD diagnosis code from the CPT procedure code at the present time but this may be reconsidered in the future if new mechanisms are developed for payment of physician services.

HOD ACTION: Substitute Recommendation for Board Report 26 adopted and the remainder of the report filed.

Board of Trustees Report 26 recommends that the referred language from Resolution 206-A-14 not be adopted and the remainder of the report filed.

Testimony on Board of Trustees Report 26 was mixed. Those speaking in favor of the report noted that the report outlines the interplay between CPT and ICD-10 and finds that a relevant connection exists. This testimony noted that the report outlines how quality measurement and reimbursement both rely on the coupling of diagnosis and services/procedures and that this tie will become more important as physicians move to alternative payment models. In contrast, testimony against the report stated that the referred language asked for the U.S. Government Accountability Office (GAO), and not our AMA, to conduct this study and that the report focused too heavily on the inpatient setting rather than addressing if uncoupling was possible for outpatient services. Additional testimony noted that the GAO recently conducted a study on ICD-10 and that its conclusions, rather than being supportive of stopping or delaying ICD-10, agreed with the Centers for Medicare & Medicaid Services' (CMS) efforts to move forward with implementation of the new code set. Testimony suggested a change to the report's recommendation by stating that the GAO not address uncoupling of ICD-10 and CPT at the present time but may consider this issue in the future if new mechanisms are developed for payment of physician services. Your Reference Committee acknowledges the complexity of ICD-10 and notes that AMA advocacy continues to call for repeal of the new code set. Recognizing the challenging environment, your Reference Committee agrees with the proposed substitute recommendation that would not compromise existing advocacy efforts but would allow for future study if warranted and feasible. Your Reference Committee therefore recommends that the substitute recommendation of Board Report 26 be adopted and the remainder of the report be filed.

(12) RESOLUTION 207 - APPROPRIATE USE OF COMPOUNDED MEDICATIONS IN MEDICAL OFFICES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 207 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support regulatory changes to improve access to 1) the compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting and 2) bulk purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded drugs for the purpose of in-office use.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 207 be adopted as amended.

HOD ACTION: Resolution 207 adopted as amended.

Resolution 207 asks that our American Medical Association support regulatory changes to improve access to 1) the compounding of manufactured FDA-approved drugs usually prepared in the office-based setting and 2) bulk purchasing from compounding pharmacies of FDA-approved drugs for the purpose of in-office use.

Your Reference Committee heard largely supportive testimony on Resolution 207. Testimony noted that current law may impede access to compounded drugs and substances and create patient access barriers to safe, effective, and medically necessary in-office, low-risk procedures. This testimony also noted that the reference to “bulk” purchasing may be misconstrued and should be removed. The Committee agrees that the reference to “bulk” purchase could be misinterpreted based on the regulatory framework used by the FDA. Your Reference Committee also agrees with the testimony presented in support of an amendment to recognize the need for access to repackaged FDA-approved drugs and substances. Your Reference Committee believes that physicians and patients should continue to have access to in-office procedures in which clean technique is routine and appropriate and therefore recommends that Resolution 207 be adopted as amended.

(13) RESOLUTION 210 - PHYSICIAN PARTICIPATION AS THE 5TH COOPERATING PARTY IN THE INTERNATIONAL CLASSIFICATION OF DISEASE SYSTEM IN THE UNITED STATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 210 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~ask the United States Department of Health and Human Services or ultimately the United States Congress to designate a physician group advocate for a group with strong physician participation~~ to be the 5th Cooperating Party for ICD-9-CM and ICD-10-CM with equal power of the current four Cooperating Parties in the planning, interpretation and deployment of ICD-9-CM, ICD-10-CM and future ICD systems; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve be amended by addition to read as follows:

RESOLVED, That our AMA seek to be invited by the United States Department of Health and Human Services to submit nominee[s] for physician group[s] or a group with strong physician participation to be designated as the 5th Cooperating Party for ICD-9-CM, ICD-10-CM and future ICD systems.

RECOMMENDATION C:

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 ask the United States Department of Health and Human Services or ultimately the United States Congress to designate a physician group to be the 5th Cooperating Party for ICD-9-CM and ICD-10-CM with equal power of the current four Cooperating Parties in the planning, interpretation and deployment of ICD-9-CM, ICD-10-CM and future ICD systems and seek to be invited by the United States Department of Health and Human Services to submit nominee[s] for physician group[s] to be designated as the 5th Cooperating Party for ICD-9-CM, ICD-10-CM and future ICD systems.

Your Reference Committee heard generally supportive testimony with respect to Resolution 210. Testimony in support of this Resolution noted that physicians should be included in the process of developing guidelines for ICD

codes and that any group should be representative of all physicians and not a single specialty. Testimony also called for our AMA to be directly nominated to this organization; however, others noted that such involvement is resource intensive and that current parties have strongly resisted such a membership change to due conflicting interests, which may create significant barriers for our AMA to become directly involved. Further, your Reference Committee notes that becoming a Cooperating Party would make it difficult for our AMA to criticize the ICD-10 code set and its implementation. Limiting representation only to our AMA may therefore restrict efforts to improve physician representation in this process. With this in mind, your Reference Committee believes an amendment to this resolution could more broadly call for our AMA to advocate for representation by an entity with strong physician participation. Your Reference Committee agrees with this testimony and believes that the proposed amendment allows more flexibility for AMA advocacy and will ensure that relevant physician stakeholders that represent all physicians can be considered. Accordingly, your Reference Committee recommends that Resolution 210 be adopted as amended.

(14) RESOLUTION 211 - ICD-10 IMPLEMENTATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 211 be adopted.

RESOLVED, If a delay of ICD-10 implementation is not feasible, that our American Medical Association ask the Centers for Medicare & Medicaid Services (CMS) and other payers to allow a two-year grace period for ICD-10 transition, during which physicians will not be penalized for errors, mistakes, and/or malfunctions of the system. Physician payments will also not be withheld based on ICD-10 coding mistakes, providing for a true transition where physicians and their offices can work with ICD-10 over a period of time and not be penalized; and be it further

RESOLVED, That our AMA educate physicians of their contractual obligations under Medicare and insurance company contracts should they decide to not implement ICD-10 and opt to transition to cash-only practices which do not accept insurance; and be it further

RESOLVED, That our AMA aggressively promote this new implementation compromise to Congress and CMS since it will allow implementation of ICD-10 as planned, and at the same time protect patients' access to care and physicians' practices; and be it further

RESOLVED, That our AMA provide the needed resources to accomplish this new compromise ICD-10 implementation and make it a priority; and be it further

RESOLVED, That our AMA seek data on how ICD-10 implementation has affected patients and changed physician practice patterns, such as physician retirement, leaving private practice for academic settings, and moving to all-cash practices and that, if appropriate, our AMA release this information to the public.

HOD ACTION: Substitute Resolution 211 adopted.

Resolution 211 asks that if a delay of ICD-10 implementation is not feasible, that our American Medical Association ask CMS to allow a two-year grace period for ICD-10 transition, during which physicians will not be penalized for errors, mistakes, and/or malfunctions of the system. Physician payments will also not be withheld based on ICD-10 coding mistakes, providing for a true transition where physicians and their offices can work with ICD-10 over a period of time and not be penalized; ask Congress or CMS to find a way to relieve physicians of their contractual obligations under Medicare and insurance company contracts should they decide to not implement ICD-10 and opt

to transition to cash-only practices which do not accept insurance; aggressively counter the misinformation currently being promulgated by CMS and the Coalition for ICD-10; and if there is no compromise to the flawed implementation of ICD-10 by September 1, 2015, our AMA Board of Trustees consider the feasibility and likelihood of success in pursuing a judicial remedy to prevent this government mandate from closing physician practices and harming their patients.

Your Reference Committee heard strong testimony in support of the goals of Resolution 211. Testimony recognized that our AMA will continue to prioritize our existing AMA policy that first seeks to stop the implementation of the ICD-10 code set and, only if a delay is not feasible, seek mitigation strategies. The sponsor of Resolution 211 offered a comprehensive substitute resolution that urges our AMA to allow a two-year grace period, educate physicians on ways to transition to cash practices, and aggressively promote as well as prioritize these efforts, especially given the impeding deadline of October 1, 2015. Other testimony agreed with this strategy and sought an additional resolve that would ask our AMA to seek data on the impact of ICD-10 on patients and practice patterns, so that we can further evaluate and advocate for needed improvements and protections for physicians. In addition, testimony asked that an explicit date reference be removed from the offered substitute resolution to reflect that ICD-10 could be further delayed for physicians. Based on this extensive testimony, your Reference Committee recommends a substitute resolution that encompasses the goals expressed in testimony. Your Reference Committee believes that the language of this substitute resolution combines the many proactive recommendations to allow our AMA broad authority to continue to seek all available solutions while highlighting the financial and administrative burden of ICD-10. Your Reference Committee therefore recommends that Substitute Resolution 211 be adopted.

(15) RESOLUTION 214 - FUNDING FOR TEACHING HEALTH CENTER
GRADUATE MEDICAL EDUCATION PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 214 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs of ~~\$230 million~~ to continue the training of primary providers in community based Health Centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations ~~an expanding ACA will be required to serve in future years~~.

RECOMMENDATION B:

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

HOD ACTION: Resolution 214 adopted as amended.

Resolution 214 asks that our American Medical Association encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full funding needs of \$230 million to continue the training of primary providers in community based Health Centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations an expanding ACA will be required to serve in future years.

Your Reference Committee heard unanimous testimony supporting the intent of Resolution 214. In particular, testimony noted that Teaching Health Centers play a vital role by expanding graduate medical education opportunities and providing care in medically underserved areas, meeting the needs of patients who are geographically isolated and economically vulnerable. Testimony also noted that the recently enacted Medicare Access and CHIP Reauthorization Act of 2015 provided an additional \$120 million in funding for the program through 2017. Testimony, however, was concerned that the Resolution included an explicit dollar amount, which may not be the appropriate funding amount in the future, and therefore offered an amendment to this language. Your Reference Committee acknowledges the important role of Teaching Health Centers and agrees that the program

should continue to be fully funded. Your Reference Committee therefore recommends adoption of Resolution 214 as amended.

(16) RESOLUTION 216 - PREVENTING FIREARM-RELATED INJURY AND MORBIDITY IN YOUTH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~collaborate with firearms owners and training organizations to develop and distribute identify and support the distribution of~~ firearm safety materials that are appropriate for the clinical setting.

RECOMMENDATION B:

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

HOD ACTION: Resolution 216 adopted as amended.

Resolution 216 asks that our American Medical Association collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting.

Testimony heard by your Reference Committee in support of Resolution 216 emphasized that firearm-related injury or death is a major public health issue in the United States, highlighting that there is at least one firearm in approximately 35 percent of homes with children up to 18 years of age, one of three handguns is kept loaded and unlocked, and 73 percent of children under age 10 reported knowing the location of their parents' firearms. Your Reference Committee notes that current AMA policy strongly supports educating and counseling patients about firearm safety, and that the U.S. Preventive Services Task Force states that behavioral counseling interventions in clinical settings have been found to produce clinically meaningful changes in the population. However, your Reference Committee also heard conflicting testimony against adoption on the grounds that other organizations have already developed firearm safety materials that are appropriate for the clinical setting, including the American Academy of Pediatrics, and that our AMA has limited resources and expertise to develop such materials. Your Reference Committee agrees that firearm safety materials appropriate for the clinical setting are important, and believes that our AMA can play an important role by identifying and supporting the distribution of such materials that have already been developed. Accordingly, your Reference Committee recommends that Resolution 216 be adopted as amended.

(17) RESOLUTION 222 - MEDICARE AND SEQUESTRATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association take all necessary legislative and administrative steps to ~~immediately eliminate the hidden 2% "sequestration" Medicare payment cuts for physicians, prevent extended or deeper sequester cuts in Medicare payments.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 222 be adopted as amended.

HOD ACTION: Resolution 222 adopted as amended.

Resolution 222 asks that our American Medical Association take all necessary legislative and administrative steps to immediately eliminate the hidden 2% “sequestration” Medicare payment cuts for physicians.

Your Reference Committee heard resoundingly supportive testimony opposing the sequester payment cuts, but also concerns about whether Resolution 222 is addressing the right issue at this time given the current political environment is seeking to expand and not eliminate the sequestration cuts. Other testimony noted that existing AMA policy already asks that our AMA seek to find a more reasonable solution and remove certain services from the sequestration cuts, and that this policy would be duplicative of these efforts. Your Reference Committee agrees with the comments that combatting expansion of the sequester is the appropriate priority in the current political climate. Thus, we recommend an amendment that reflects this concern and support adoption of Resolution 222 as amended.

(18) RESOLUTION 224 - ELECTRONIC MEDICAL RECORDS VENDOR ACCOUNTABILITY
 RESOLUTION 227 - PARTIAL CREDIT FOR ELIGIBLE PROFESSIONALS FOR ACCOMPLISHING MEANINGFUL USE GUIDELINES
 RESOLUTION 228 - REPEAL COMPULSORY ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 224 in lieu of Resolutions 227 and 228.

RESOLVED, That our American Medical Association reaffirm policies D-478.982, H-478-991, and D-478.994; and be it further

RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services and other relevant stakeholders to allow for partial credit for the eligible professionals accomplishing one or more objectives in the meaningful use program; and be it further

RESOLVED, That our AMA engage with electronic health record (EHR) vendors to develop and provide mitigation strategies and continuity training solutions to reduce the negative effects of system downtime and other technology disruptions; and be it further

RESOLVED, That our AMA seek to mitigate the expense and loss of productivity caused by technology failures by advocating for hardship exemptions from the Meaningful Use program for eligible professionals who experience these problems; and be it further; and be it further

RESOLVED, That our AMA develop model language to be included in EHR vendor contracts with eligible professionals that protects the eligible professional in the event of downtime due to vendor error and other technology problems.

HOD ACTION: Substitute Resolution 224 referred.

Resolution 224 asks that our American Medical Association work with members of Congress to educate them about physician concerns regarding downtime for the electronic medical record (EMR) and accountability of the EMR vendors for events that occur due to that downtime; establish policy addressing electronic medical record (EMR) vendor accountability for the product sold to hospitals and physicians, including for loss of productivity for physicians due to the inability to care for patients, for medical errors that can occur due to the lack of the medical record during unexpected downtime, and for patient safety during downtime of the EMR; establish policy that EMR vendors should be accountable for downtime that is related to vendor issues; and develop model language to be included in EMR vendor contracts with physicians that protects the physician in the event of downtime due to

vendor error. Resolution 227 asks that our American Medical Association study the feasibility and framework for partial credits to eligible professionals to achieve one or more parameters of the meaningful use guidelines and work with the Centers for Medicare & Medicaid Services and relevant agencies to come up with mechanisms for partial credit to the eligible providers accomplishing one or more tasks in the meaningful use guidelines. Resolution 228 asks that our American Medical Association reaffirm policies D-478.982, H-478-991, and D-478.994; advocate that the United States Congress act rapidly to repeal compulsory electronic health records by (1) eliminating all penalties for nonparticipation in the Medicare EHR Incentive Program and (2) eliminating all Merit-Based Incentive Payment System (MIPS) penalties related to noncompliance with meaningful use criteria.

Testimony received by your Reference Committee was strongly supportive of Resolutions 224, 227, and 228. Many emphasized that the Meaningful Use (MU) program is a significant cost and disruption to eligible professional practices, and that physicians should not be penalized for technology that is not capable of seamlessly exchanging patient data and improving physician workflow. Those testifying also stated that electronic health record (EHR) vendors lack accountability for the problems with EHRs, including system down times and the lack of usability of EHR systems.

Specifically with respect to Resolution 224, testimony noted that loss of productivity continues to be a problem and that our AMA should seek solutions to reduce the costs, medical errors, and patient safety issues related to EHRs. Testimony also noted that AMA advocacy is already working with Congress to educate them about these concerns, including working with relevant Committees to improve interoperability and supporting legislation that would allow for a 90-day reporting period, mitigating the amount of time physicians must spend on meeting MU measures. Other testimony noted that Congress had previously offered misguided enforcement provisions that, while directed at vendors, created new burdens and costs for eligible professionals. Those testifying suggested an amendment that calls for more specific actions including, seeking mitigation strategies for system downtime, exemptions from the MU program penalties for technology failures, as well as model language to protect eligible professionals in vendor contracts.

Regarding Resolution 227, testimony noted that our AMA has already vetted the approach of partial credit and is actively calling for removal of the all-or-nothing construct of the Meaningful Use program, which is highlighted in numerous comment letters to agency officials and other advocacy documents. While testimony referred to a letter that specifically used percentages, 50 percent and 75 percent, to determine incentives and penalties, our AMA's most recent letters on Stage 3 include broader language that we believe is consistent with the intent of this Resolution. Testimony also noted that other physician quality reporting programs do not operate on a pass-fail basis, providing precedent for a more flexible approach.

With respect to Resolution 228, testimony highlighted that existing AMA policy already calls for the removal of MU payment adjustments and that AMA's pay-for-performance principles would continue to encourage removal of penalties even when the program is incorporated into the Merit-based Incentive Payment System (MIPS). The Council on Legislation offered a substitute amendment that would combine the goals of and reflect the testimony on these resolutions. Your Reference Committee agrees with the testimony and recognizes the extensive AMA policy and advocacy that addresses EHRs and the MU program. Therefore, your Reference Committee recommends adoption of substitute Resolution 224 in lieu of Resolutions 227 and 228.

(19) RESOLUTION 225 – MAKE SIMPLICITY THE FOREMOST CRITERIA FOR ANY CMS PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 225 be amended by addition to read as follows:

RESOLVED, That our American Medical Association continue to advocate for simplicity in any current or future programs initiated by the Centers for Medicare & Medicaid Services (CMS) that impact physicians; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 225 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA continue to advocate by all means necessary that any current or future programs initiated by the Centers for Medicare and Medicaid Services be summarized into an executive summary format or other format that is easily comprehensible to everyone in a medical office physicians, medical staff and administration in a medical office.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 225 be adopted as amended.

HOD ACTION: Resolution 225 adopted as amended.

Resolution 225 asks that our American Medical Association advocate for simplicity in any current or future programs initiated by the Centers for Medicare & Medicaid Services (CMS), and that our American Medical Association advocate by all means necessary that any current or future programs initiated by CMS be summarized into an executive summary format easily comprehensible to everyone in a medical office.

Your Reference Committee heard supportive testimony of the general aims of Resolution 225, but also of the need for refinements to narrow the focus of the goals of this Resolution and to reflect current CMS efforts and AMA advocacy. Testimony specifically noted that CMS frequently issues summaries and fact sheets for its proposed and final regulations; yet, the agency may be unable to provide more information because of its limited resources. Other testimony noted that the first resolve could encompass issues not relevant to physicians and that the second resolve could be challenging to implement if required to be comprehensible to everyone in a medical office. Testimony, however, strongly noted that physicians should have access to comprehensible information regarding the programs that affect the care they provide patients. Your Reference Committee agrees with this testimony and recommends amending Resolution 225 to address these concerns. Your Reference Committee therefore recommends that Resolution 225 be adopted as amended.

(20) RESOLUTION 229 – PHYSICIAN SELF-MONITORING OF CONTROLLED SUBSTANCE PRESCRIPTIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the National Alliance for Model State Drug Laws (NAMSDL), as well as other appropriate national organizations and stakeholders, to update the NAMSDL's Model Prescription Monitoring Program Act to provide health care professionals the opportunity to review self monitor their schedule 2-5 controlled substance prescribing patterns as a means to help monitor appropriate prescribing and detect and identify fraudulent prescriptions dispensed under their respective Drug Enforcement Administration numbers.

RECOMMENDATION B:

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

HOD ACTION: Resolution 229 adopted as amended.

Resolution 229 asks that our American Medical Association work with the National Alliance for Model State Drug Laws (NAMSDL), as well as other appropriate national organizations and stakeholders, to update the NAMSDL's Model Prescription Monitoring Program Act to provide health care professionals the opportunity to self-monitor their schedule 2-5 controlled substance prescribing patterns as a means to detect and identify fraudulent prescriptions dispensed under their respective Drug Enforcement Administration numbers.

Your Reference Committee heard generally supportive testimony on Resolution 229. Testimony noted that Prescription Drug Monitoring Programs (PDMPs) can be helpful clinical tools to provide physicians with information about their own prescribing practices and their patients' prescription history. Testimony also noted that, while physicians largely do not have access to their prescribing data, law enforcement agencies do. The Council on Legislation offered an amendment to Resolution 229 to align it with advocacy that focuses on ensuring PDMPs are useful clinical tools rather than used for law enforcement purposes. The amendment offered would also further allow a physician to review the PDMP information and permit a physician to see his or her prescribing history as well as the history of his or her patients. Your Reference Committee agrees with this testimony and believes, however, that the amendment to this resolution captures the goals of the original Resolution. Therefore, your Reference Committee recommends adoption of Resolution 229 as amended.

(21) RESOLUTION 233 - IMMUNITY FROM FEDERAL PROSECUTION FOR MARIJUANA PRESCRIBING PHYSICIANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 233 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support legislation ensuring or providing immunity against federal prosecution for physicians who prescribe certify that a patient has an approved medical condition or recommend medical cannabis marijuana in accordance with their state's laws.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 233 be adopted as amended.

RECOMMENDATION C:

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

**IMMUNITY FROM FEDERAL PROSECUTION FOR ~~CANNABIS~~
~~PRESKRIBING~~ PHYSICIANS RECOMMENDING CANNABIS**

HOD ACTION: Resolution 233 adopted as amended with change in title.

Resolution 233 asks that our American Medical Association support legislation ensuring or providing immunity against federal prosecution for physicians who prescribe marijuana in accordance with their state's laws.

Your Reference Committee heard limited testimony on Resolution 233. Your Reference Committee heard general support for an amendment to reflect that physicians do not prescribe medical cannabis, but rather, certify that a patient has an approved medical condition or recommend medical marijuana. Further testimony was presented that adoption of this resolution would be consistent with AMA policy to protect patient-physician communications about treatment options, supporting a public health approach, rather than a law-enforcement focus, for individuals possessing cannabis for personal use, and opposing government interference with the practice of medicine and compromising the ability of physicians to exercise their clinical judgment about the best treatments for their patients without fear of prosecution. To be consistent with existing AMA policy on this subject matter, your Reference

Committee also recommends a change in the title of this Resolution to refer to cannabis rather than marijuana. Accordingly, your Reference Committee recommends that Resolution 233 be adopted as amended.

(22) RESOLUTION 236 - VALUE BASED MODIFIER AND FLAWED DRUG COST ATTRIBUTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 236 be amended by addition to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to modify Value Based Modifier cost attribution with regard to all drug costs, to ensure the cost calculation does not unfairly disadvantage certain providers.

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 work with the Centers for Medicare & Medicaid Services to modify Value Based Modifier cost attribution with regard to drug costs, to ensure the cost calculation does not unfairly disadvantage certain providers.

Your Reference Committee heard largely supportive testimony regarding Resolution 236. Testimony noted that disparate treatment of the costs of Part B versus Part D medications can have an unfair impact on certain physicians under the Value Based Modifier (VBM) and result in the greater likelihood of penalties. Testimony also noted that physicians should not be forced to make drug choices that may not improve patient care because of the flawed VBM approach to drug costs. Others noted that when the Merit-Based Incentive Payment System replaces the VBM in 2019, the costs of Part D as well as Part B drugs will be included in the costs attributed to physicians, providing a more fair assessment. A minor amendment was offered to ensure that all drug costs would be considered. Your Reference Committee agrees with this testimony and recommends that Resolution 236 be adopted as amended to support a more balanced playing field among all physicians who face VBM penalties.

(23) RESOLUTION 237 - 96-HOUR RULE FOR CRITICAL ACCESS HOSPITALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolve 1 of Resolution 237 be amended by deletion to read as follows:

RESOLVED, That our AMA support and lobby for passage of legislation currently before Congress that would provide relief to Critical Access Hospitals from the “96-hour rule”; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 237 be adopted as amended.

HOD ACTION: Resolution 237 adopted as amended.

Resolution 237 asks that our AMA support and lobby for passage of legislation currently before Congress that would provide relief to Critical Access Hospitals (CAHs) from the “96-hour rule” and that our AMA join with other

affected stakeholders to enhance efforts for passage of legislation that would provide relief to Critical Access Hospitals from the “96-hour” rule.

Testimony on Resolution 237 was largely supportive. This testimony noted that while CAHs typically maintain an annual average of 96 hours per patient, they offer some medical services that have standard lengths of stay greater than 96 hours. Patient access to care could be negatively impacted if the 96-hour rule is strictly enforced. Your Reference Committee agrees with this testimony heard but notes that our AMA policy typically does not refer to specific legislation, as it quickly becomes out of date. To ensure our AMA policy remains relevant, your Reference Committee believes that this resolution should be amended to more generally address the goal of this Resolution. Your Reference Committee therefore recommends that Resolution 237 be adopted as amended.

(24) RESOLUTION 238 - PROTECTING PHYSICIAN LED HEALTH CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 238 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the conduct an analysis evaluating expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 238 be adopted as amended.

HOD ACTION: Resolution 238 adopted as amended.

Resolution 238 asks that our AMA conduct an analysis evaluating expanded use of allied health professionals and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that have adopted such legislation as compared to those that have not. This analysis should include consideration of practitioner settings and patient risk-adjustment.

Your Reference Committee heard limited testimony on Resolution 238. Your Reference Committee understands that with the support of our AMA Scope of Practice Partnership, our AMA has committed considerable resources to development of data including the Geographic Mapping Initiative and Health Workforce Mapper, which map the health care workforce and provide a compelling argument that the scope of practice expansions described in Resolution 238 do not result in expanded access to care. Your Reference Committee also believes that collection of the quality and outcomes data Resolution 238 requests would be an expensive and challenging endeavor for our AMA to undertake. Your Reference Committee also understands that over the past several years our AMA has undertaken an effort to work with national medical associations and other stakeholders, including large integrated health systems, to identify and collect the data anticipated by Resolution 238, but to date, such efforts have not been fruitful.

At the same time, your Reference Committee notes that national survey research conducted with the support of our AMA Scope of Practice Partnership and included in materials for our AMA Physician-Led Team Campaign indicates that patients are overwhelmingly in support in support of collaborative, physician-led health care teams and in opposition to independent practice of allied health professionals. Your Reference Committee understands that our AMA regularly communicates with state and specialty medical associations to discuss and disseminate any and all new research, including recently released studies in the Mayo Clinic Proceedings and the Journal of the

American Medical Association on independent allied health professionals' referral patterns and orders for diagnostic imaging studies, respectively.

Your Reference Committee recognizes that the need for data is paramount, particularly for scope of practice advocacy. Your Reference Committee encourages your AMA to continue to work with all relevant stakeholders, particularly members of our AMA Scope of Practice Partnership, to identify, collect, analyze, and disseminate the data anticipated by Resolution 238, and therefore recommends that Resolution 238 be adopted as amended.

(25) **BOARD OF TRUSTEES REPORT 7- REDUCING GUN VIOLENCE**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 7 be referred.

HOD ACTION: The following Substitute Recommendation was referred.

That our AMA strongly support requiring criminal background checks for all firearm purchases, including, but not limited to, sales by gun dealers, sales at gun shows, and private sales between individuals.

Board of Trustees Report 7 recommends that our AMA support legislation requiring background checks for all purchasers of firearms.

Your Reference Committee heard mixed testimony on the recommendation in Board of Trustees Report 7. A representative from the Board of Trustees testified that the recommendation in this report builds upon existing AMA policy that supports increasing the safety of firearms and their use and reducing and preventing firearm violence. While your Reference Committee agrees, there was strong testimony both for and against adoption of the recommendation as drafted, and several who testified recommended referral. Testimony from those in favor of adoption noted that firearm mortality and morbidity continues to increase and remains a major public health problem. Several who testified in support of referral and against adoption expressed concern that the wording of the recommendation only addresses the purchase of a firearm and does not include the transfer of firearms or firearms purchased at trade shows. Others who testified against adoption and for referral raised concerns that the recommendation was too broad and could extend to transfers of firearms, including antiques, to family members, or individuals who already possess the requisite clearance. Having heard diverse perspectives on this matter, your Reference Committee concluded that the recommendation in Board of Trustees Report 7 should be referred to allow additional consideration.

(26) **RESOLUTION 203 - MODEL STATE LEGISLATION ELIMINATING RESTRICTIVE COVENANTS IN PHYSICIAN CONTRACTS**

RECOMMENDATION:

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

HOD ACTION: Resolution 203 referred.

Resolution 203 asks that our American Medical Association study the development of model state legislation that eliminates restrictive covenants from physician employment agreements and contracts, with a report back to the House of Delegates at the 2015 Interim Meeting.

Your Reference Committee heard extensive testimony related to the increasingly important issue of restrictive covenants. Your Reference Committee supports the underlying intent of this resolution, and agrees with testimony noting the need for sensitivity to smaller physician practices and their use of restrictive covenants. Our AMA updated its "Annotated Model Physician-Hospital Employment Agreement" (Model Agreement) in 2014 and as such, has access to a list of representative state statutes pertaining to restrictive covenants. Our AMA's Advocacy

unit, along with our Council on Legislation, is actively working on developing a state-based advocacy toolkit, including model legislation on a variety of issues addressed in the Model Agreement that would ensure that physicians are protected as they move in and out of different employment or practice arrangements including restrictive covenants. Testimony reflected divergent views on the impact of restrictive covenants based on practice settings, size, and employment status. It is recognized that this may not be an issue where one size fits all and therefore, given the complexity of the current employment environment for physicians, the need and opportunity for physician education on this and other contractual issues and the commitment of our AMA to ensure the viability of all physician practices, your Reference Committee recommends referral of Resolution 203.

(27) **RESOLUTION 204 - NOMINATION FOR AND IMPROVEMENT OF THE POSITION OF THE SURGEON GENERAL OF THE UNITED STATES**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 204 be referred.

HOD ACTION: Resolution 204 referred.

Resolution 204 asks that whenever there is a vacancy in the position of the US Surgeon General, the American Medical Association Council on Science and Public Health provide the names of three individuals for consideration to the AMA Candidate Review Committee for approval, after which the names will be forwarded to the AMA Board of Trustees for final consideration. The individuals' names and credentials will then be submitted by the AMA Board of Trustees to the President of the United States through the appropriate submission procedures for consideration of appointment to the position of US Surgeon General, with final approval by the United States Senate and the findings of that task force be forwarded to the AMA Council on Legislation for the purpose of having it draft legislation that, upon approval of the of the AMA Board of Trustees, can be brought forward to the United States Congress for passage into law with the anticipation that improvement in the overall function of the Office of the US Surgeon General can be achieved and, therefore, result in fewer vacancies in the position of US Surgeon General.

Your Reference Committee heard generally supportive testimony on the intent of Resolution 204, but also heard several concerns with the specific wording of this Resolution. Testimony was presented that, over time, the power of the position of Surgeon General has been politicized and weakened, and that during the recent Ebola crisis, the United States lacked a spokesperson to minister to the health of its citizens because the Surgeon General had not yet been confirmed and instead, there was an acting Surgeon General in place. In addition, testimony highlighted that there was a need to strengthen the position of the Surgeon General to better advocate for the health of the citizens of the U.S., and to improve the function of the Office of Surgeon General, which would result in fewer vacancies in the position. Your Reference Committee also heard testimony that concern over the weakening of the Surgeon General's position seems to reflect a view of the Surgeon General's role that is more aspirational than practical. For example, in the Ebola situation, the Center for Disease Control and Prevention director's responsibility and resources were far more relevant.

Testimony highlighted concerns with the first and third resolve and whether this process was consistent with AMA procedures. Testimony noted that our AMA already has a process for recommending and supporting proposed nominees through the Board of Trustees Candidate Review Committee. Your Reference Committee notes that the process recommended by this resolution would add an additional step and a search by the Council of Science and Public Health would consume considerably more time and staff resources. Testimony further noted that the second resolve, seeking a task force, may be more feasible. Yet, your Reference Committee notes that the Resolution requires a task force of former Surgeons Generals, who may not be willing or available to serve in this role. Currently these organizational decisions reside with the Secretary of HHS and ultimately with the White House; recommendations from an outside organization would carry little weight and may not be well-received. Your Reference Committee concludes that the preponderance of the testimony raises significant questions with the approach taken by this resolution, and that points heard weigh for referral to consider other opportunities for our AMA to weigh-in on how to support the role of the Surgeon General. Accordingly, your Reference Committee recommends Resolution 204 be referred for future study.

(28) RESOLUTION 202 - MEASURING THE EFFECT OF PAID SICK LEAVE ON HEALTH CARE OUTCOMES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 202 be referred for decision.

HOD ACTION: Resolution 202 referred.

Resolution 202 asks that our American Medical Association recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave and work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted paid sick leave legislation.

Your Reference Committee heard mixed testimony on Resolution 202. Testimony was presented that over 40 million U.S. workers, almost 40 percent, of the country's workforce, currently have no ability to accrue paid sick leave (PSL) and that lack of access to PSL is a public health issue that can result in delayed screenings, diagnoses, and treatment. Your Reference Committee heard general agreement that the first Resolved would be premature for our AMA to adopt without clear data in support. Mixed testimony also discussed the appropriateness of our AMA endorsing a mandate on our country's businesses. Testimony was also presented that the issue of mandatory paid sick leave is more of an employee benefits issue and that studying the economic and health impacts of PSL may not be the best use of our AMA's limited resources. Your Reference Committee believes that our AMA Board of Trustees is best suited to consider the issues presented in light of AMA resources and strategic priorities, and therefore recommends that Resolution 202 be referred for decision.

(29) RESOLUTION 219 - NEED TO CREATE A SPECIAL INSPECTOR GENERAL FOR MONITORING THE AFFORDABLE CARE ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 219 not be adopted.

HOD ACTION: Resolution 219 not adopted.

Resolution 219 asks that our American Medical Association support the creation of a special inspector general to oversee the implementation of the Affordable Care Act (ACA).

Your Reference Committee heard very limited testimony on Resolution 219 with the sponsor of the Resolution being the only individual to testify. This testimony simply noted that the Resolution was offered for consideration. Given this limited testimony and that a similar Resolution was considered at the 2014 Annual Meeting, and was not adopted by the House of Delegates, your Reference Committee believes the same action should be upheld. Accordingly, your Reference Committee recommends that Resolution 219 not be adopted.

(30) RESOLUTION 201 - BEST PRACTICES FOR MOBILE MEDICAL APPLICATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-480.975 be reaffirmed in lieu of Resolution 201.

HOD ACTION: Resolution 201 adopted as amended.

That our American Medical Association develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.

Resolution 201 asks that our American Medical Association develop and publically disseminate a list of best practices guiding the development of mobile medical applications.

Your Reference Committee heard supportive testimony on Resolution 201. Testimony, however, noted that AMA policy D-480.975 Guidelines for Mobile Medical Applications and Devices adopted at the Annual 2013 meeting already calls for a report on mobile medical applications and devices. The Council on Science and Public Health (CSAPH) prepared a report, which was adopted at Annual 2014, and included new policy that provides that our AMA will continue to engage with stakeholders to identify relevant guidance principles to promote mobile app innovation, and that our AMA will support physician education and resources to assist physicians in becoming familiar with mobile health apps that are clinically useful and evidence based. Testimony also noted that the Council on Long Term Planning is preparing a report on digital health for consideration at Annual 2015 and the Council on Legislation will consider principles related to mobile medical devices at Annual 2015 that will be considered by the Board. Given this ongoing work, your Reference Committee believes that the concerns outlined in Resolution 201 will be addressed by these ongoing efforts and therefore believes that existing policy D-480.975 should be reaffirmed in lieu of adopting Resolution 201.

D-480.972 Guidelines for Mobile Medical Applications and Devices

1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.

(31) RESOLUTION 208 - REDUCE REPORTING BURDEN AND CONFUSION

RESOLUTION 223 - AUTOMATIC TRACKING OF QUALITY

INDICATORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-478.995 and H-450.966 be reaffirmed in lieu of Resolutions 208 and 223.

HOD ACTION: Policies D-478.995 and H-450.966 reaffirmed in lieu of Resolutions 208 and 223.

Resolution 208 asks that our American Medical Association actively engage the Centers for Medicare & Medicaid Services, EHR developers, representatives of the commercial payers, and other interested parties, to develop a unified glossary of definitions, panel of metrics, and standard fields and formatting for the reporting of quality performance and outcomes data that meet the AMA “Pay-for-Performance Principles and Guidelines.” Resolution 223 asks that our American Medical Association strongly urge the Office of the National Coordinator for Health Information Technology to require electronic medical records vendors’ systems to have the capability to automatically track indicators for the purpose of quality monitoring for all specialties once the data is in the electronic medical record.

Your Reference Committee heard supportive testimony on Resolutions 208 and 223; however, testimony also noted that our AMA has existing policy and extensive advocacy addressing the concerns of these two resolutions. In particular, our AMA created both the Physicians Consortium for Performance Improvement (PCPI) as well as the National Quality Registry Network (NQRN) to assist in the development of quality measures and registries for physician quality reporting and actively advances the idea of measure alignment, unified definitions, and common core data sets. Testimony also noted that Resolution 223 specifically addresses electronic health records (EHRs) and that this resolution could be relevant to Resolution 224 on vendor accountability. Your Reference Committee notes that our AMA is also actively working EHR vendors to improve quality tracking and reporting for the Meaningful Use and other quality reporting programs and recognizes that this process is facing numerous technology challenges that must be systematically addressed. Thus, your Reference Committee supports the general goals of Resolutions

208 and 223 but recommends reaffirmation of existing policy D-478.995 and H- 450.966 in lieu of adoption to avoid disrupting ongoing advocacy activities.

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 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 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 EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

H-450.966 Quality Management

The AMA: (1) continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured

(32) RESOLUTION 213 - TAMPERING WITH THE IN-OFFICE ANCILLARY SERVICES EXCEPTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-270.995 be reaffirmed in lieu of Resolution 213.

HOD ACTION: Policy D-270.995 reaffirmed in lieu of Resolution 213.

Resolution 213 asks that our American Medical Association work aggressively to preserve and protect the In-Office Ancillary Services Exception (IOASE) from any modification through the President's 2016 Budget (e.g., prohibiting referrals for radiation therapy, therapy services, advanced imaging and anatomic pathology services) or any other legislative mechanism or regulatory process and report relevant AMA efforts to this House on not less than an annual basis.

Testimony was supportive of Resolution 213 and recognized the importance of maintaining the IOASE to the Stark Law. Testimony, however, noted that this Resolution is almost identical to existing Directive-270.995, which calls for our AMA to oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services. This testimony noted that the adoption of the Resolution would be duplicative and that the addition of a call for an annual report would be required in perpetuity, regardless if there are any pertinent legislative or regulatory challenges to this provision. Moreover, testimony noted that our AMA is already in the process of providing an analysis of services affected by the IOASE to promote advocacy on this issue before Congress and other federal authorities and is sharing this analysis with relevant specialties. Based on this testimony, your Reference Committee agrees that this resolution is similar to existing AMA policy and that requiring an annual report, while relevant currently, may divert staff resources in the future. Given that our AMA is in the process of providing analysis of services impacted by the IOASE to promote advocacy on this topic, your Reference Committee recommends reaffirmation of existing D-270.995 in lieu of Resolution 213.

D-270.995 Physician Ownership and Referral for Imaging Services

Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.

(33) RESOLUTION 215 - HEALTH CARE REFORM MODEL LEGISLATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-165.833, H-165.835, H-165.838, D-165.938, and D-165.940 be reaffirmed in lieu of Resolution 215.

HOD ACTION: Policies H-165.833, H-165.835, H-165.838, D-165.938, and D-165.940 reaffirmed in lieu of Resolution 215.

Resolution 215 asks that our American Medical Association (AMA) Board of Trustees identify which of the 13 points in Policy H-165.838 have been accomplished by the Affordable Care Act of 2009 (ACA), which have not, and which are contravened by the ACA, and report its findings to the House of Delegates at the 2015 Interim Meeting, along with a reasoned recommendation for or against the drafting and publication by the AMA of model legislation that embodies the principles of health care reform legislation stated in Policy H-165.838.

Your Reference Committee heard mixed testimony on Resolution 215. Testimony in support of the resolution clarified that the main goal of this resolution was to direct our AMA to produce model legislation that would be used as a starting point to improve health care reform efforts. Other testimony, however, was presented that AMA Policy H-165.838 already covers the intent of Resolution 215. This testimony noted that AMA Policy H-165.838 sets forth 13 necessary components of health care reform supported by our AMA and that the Board should identify which of these components have been accomplished in a report to be presented at I-15, along with recommendations on model legislation to be drafted by our AMA.

Additional testimony noted that the goal of this Resolution is also encompassed in existing AMA policies D-165.940, D-165.938, H-165.833, and H-165.835 on health care reform principles and the ACA, as well as past and

ongoing AMA advocacy activities to improve the ACA. Testimony by a representative of our AMA's Council on Legislation noted that most of the elements called for in H-165.838 have either been accomplished or are actively being pursued by our AMA through its advocacy activities, including a mandate that most American citizens or legal residents obtain health insurance coverage; insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; investments and incentives for quality improvement and prevention and wellness initiatives; repeal of the Medicare physician payment formula; implementation of medical liability reforms to reduce the cost of defensive medicine; and streamlined and standardized insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

Your Reference Committee takes note that several CMS and Board reports on the ACA have been written and presented to the House of Delegates, including CMS Report 5-I-13, which provided background on how the ACA relates to AMA policy, and outlined the expected coverage, budgetary and physician-practice impacts of the law (pursuant to D-165.940). Reports have been submitted to the HOD at I-13, A-14, and I-14, and another will be submitted at A-15 pursuant to D-165.938, which calls on our AMA to develop a policy statement clearly stating AMA policies on the various aspects of the ACA and health care reform. Finally, our AMA has already created six model bills to help states address some of the key issues raised by the ACA, including legislation on narrow and tiered networks, network adequacy resources, issues related to the grace period. Your Reference Committee believes that the asks in Resolution 215 have already been accomplished in the foregoing AMA reports and advocacy activities, and therefore recommends that AMA Policies H-165.833, H-165.835, H-165.838, D-165.938 and D-165.940 be reaffirmed.

H-165.833 Amend the Patient Protection and Affordable Care Act (PPACA)

1. Our AMA continues to advocate achieving needed reforms of the many defects of the federal Patient Protection and Affordable Care Act (PPACA) law so as to protect the primacy of the physician-patient relationship. These needed changes include but are not limited to: - repeal of the Independent Payment Advisory Board (IPAB); - study of the Medicare Cost/Quality Index; - repeal of the non-physician provider non-discrimination provision; - enactment of comprehensive medical liability reform; - enactment of long term Medicare physician payment reform including permitting patients to privately contract with physicians not participating in the Medicare program; - enactment of antitrust reform to permit independently practicing physicians to collectively negotiate with health insurance companies; and - expanding the use of health savings accounts as a means to provide health insurance coverage. 2. Our AMA will vigorously work to change the PPACA to accurately represent our AMA Policy.

H-165.835 AMA Advocacy for Health System Reform

1. Our AMA will advocate for modification of the Patient Protection and Affordable Care Act through legislation, regulation or judicial action to remove or oppose any components of the Act that are not consistent with existing AMA policy. 2. Our AMA will identify the major flaws in the Patient Protection and Affordable Care Act and advocate repair of those flaws. 3. Our AMA will educate the physicians of these United States in the details and implementation of the PPACA legislation.

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. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform. 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

D-165.938 Redefining AMA's Position on ACA and Healthcare Reform

1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform: A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines; B. Repeal and appropriate replacement of the SGR; C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines; D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting"); E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations; F. Repeal the non-physician provider non-discrimination provisions of the ACA. 2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals. 3. There will be a report back at each meeting of the AMA HOD.

D-165.940 Monitoring the Affordable Care Act

Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary, coverage and physician-practice impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting.

(34) RESOLUTION 218 - ACTION TO ENSURE ACCESS TO HEALTHCARE AND CHOICE OF PHYSICIAN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-383.992, H-380.987 be reaffirmed in lieu of Resolution 218.

HOD ACTION: Policies H-383.992, H-380.987 reaffirmed in lieu of Resolution 218.

Resolution 218 asks that our American Medical Association support passage of legislation that prohibits everyone including the federal government from detrimental anti-competitive price fixing and predatory pricing.

Your Reference Committee heard mixed testimony with respect to Resolution 218. Testimony generally noted that price fixing and predatory pricing can negatively impact physician practices. Yet, others testified that this resolution places an incredibly broad prohibition that is unlikely to be accomplished and may hinder AMA advocacy efforts to target feasible improvements for physicians. Testimony noted that our AMA already has more limited policy that pursues changes in the law that would give physicians antitrust relief and help them offset health insurer and other payer dominance. Your Reference Committee recognizes the valid intent of this Resolution but agrees that existing policy is more narrowly focused. Therefore, your Reference Committee recommends reaffirmation of existing AMA Policies H-383.992 and H-380.987 in lieu of Resolution 218.

H-383.992 Antitrust Relief

Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers.

H-380.987 Antitrust Relief as a Priority of the AMA

Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association.

REPORT OF REFERENCE COMMITTEE C

(1) COUNCIL ON MEDICAL EDUCATION REPORT 4 - GUIDELINES FOR STUDENTS SHADOWING PHYSICIANS

RECOMMENDATION:

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

**HOD ACTION: Recommendations in Council on Medical Education Report 4
adopted and the remainder of the report filed.**

Council on Medical Education Report 4 asks that our AMA 1) encourage physicians in both private practice and academic settings to provide shadowing opportunities to students interested in a career in medicine—particularly those from underrepresented populations—as part of the physician’s commitment to the future of the profession; 2) encourage physicians to adopt the most appropriate shadowing model to the needs of the practice/institution and the student(s); and 3) endorse the clinical shadowing guidelines for students from the Association of American Medical Colleges as one model for such students and help disseminate this document to K-12 students, premedical students, health professions advisors, hospitals, and physicians.

Your Reference Committee heard unanimous testimony in favor of this item. Testimony reflected that this iteration addressed concerns from the earlier version, presented at the A-14 HOD meeting. The report’s recommendations, while encouraging physicians to participate in shadowing as a professional responsibility, allow leeway for adaptation to meet local needs and circumstances. In addition, the report calls attention to the need to provide shadowing opportunities to minority populations that are under-represented in medicine. It was noted that hospital volunteering is preferable to shadowing as a true measure of interest in a career in medicine; this may be the topic of a future resolution or report. Your Reference Committee recommends adoption of this report.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 7 - ENHANCING THE AMA’S ROLE IN PREMEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 7 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Education Report 7
adopted and the remainder of the report filed.**

Council on Medical Education Report 7 asks that our AMA 1) update its “Becoming a Physician” website with most relevant information to enhance usage and usability, and support the concept and explore the feasibility of enhancing current AMA online resources for premedical students; 2) explore the feasibility of developing innovative online “premedical” engagement activities that are affordable to students and cost-effective for our AMA and have value to medical school admissions personnel; and 3) explore the feasibility of developing resources to enhance premedical student advising and mentoring by physicians and others.

Your Reference Committee heard unanimous testimony in favor of this item. This report calls on the AMA to increase exposure of undergraduates to values that are not typically emphasized in pre-medical education, particularly professionalism and humanism. While medical school admissions committees generally take a holistic approach to evaluating applicants, most guidance on admissions aimed at pre-medical students does not emphasize traits such as professionalism and humanism. This report is a timely and well-written effort to reemphasize these important values and ensure the continued high quality and ethical nature of our nation’s medical professionals. Therefore, your Reference Committee recommends adoption.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 9 - THE VALUE OF GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 9 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Education Report 9
adopted and the remainder of the report filed.**

Council on Medical Education Report 9 asks that our AMA 1) utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education; 2) revise Policy D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” to read as follows: “8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care, (including the federal government, the states, and local and private sources payers), to funding both the direct and indirect costs of GME”; 3) advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation; and 4) support recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

Your Reference Committee heard unanimous testimony in favor of adopting CME Report 9. Dissemination of the information in this report may help the public better appreciate the value of graduate medical education to the common good and recognize all the contributions of resident/fellow physicians and residency programs to the community and society as a whole, though, for example, provision of care in underserved areas. Therefore, your Reference Committee recommends adoption of CME Report 9.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 10 - ALIGNING THE EVALUATION OF PHYSICIANS ACROSS THE MEDICAL EDUCATION CONTINUUM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 10 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Education Report 10
adopted and the remainder of the report filed.**

Council on Medical Education Report 10 asks that our AMA 1) support the concept that evaluation of physicians as they progress along the medical education continuum should include the following: a) *Assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice*; and b) Use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum; 2) encourage study of competency-based progression within and between medical school and residency: a) through its Accelerating Change in Medical Education initiative, study models of competency-based progression within the medical school; and b) work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency; 3) encourage research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum; and 4) encourage ongoing research to identify best practices for workplace-based

assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.

Your Reference Committee heard unanimous testimony in favor of this item. Future study by our AMA will ensure additional evaluation of the evidence for and consideration of the consequences, challenges and opportunities of the alignment of assessment processes of practicing physicians. Therefore, your Reference Committee recommends adoption.

(5) RESOLUTION 303 - AUTONOMY IN UTILIZATION OF CME FUNDS BY EMPLOYED PHYSICIANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 303 be adopted.

HOD ACTION: Resolution 303 adopted.

Resolution 303 asks that our AMA support physician autonomy by partnering with relevant organizations to encourage medical organizations or institutions that employ physicians and offer financial support towards continuing medical education (CME) to avoid prioritizing institutional goals over individual physician educational needs in the choice of CME coursework.

Your Reference Committee heard unanimous testimony in favor of this item. Testimony noted that more physicians are working as employees, so this may become an increasingly common concern going forward. Physicians need to maintain the autonomy to get the education they need, as one of the key components of physician professional competence. The individual doctor should be the arbiter of the relevance of a given educational program, rather than his/her employer or institution. In short, the specific needs of a given physician should be the priority in allocation of CME funding. Therefore, your Reference Committee recommends adoption of Resolution 303.

(6) RESOLUTION 305 - EVALUATION OF DACA-ELIGIBLE MEDICAL STUDENTS, RESIDENTS, AND PHYSICIANS IN ADDRESSING PHYSICIAN SHORTAGES

RECOMMENDATION:

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

HOD ACTION: Resolution 305 adopted.

Resolution 305 asks that our AMA study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.

Your Reference Committee heard unanimous testimony in favor of Resolution 305. A total of 1.8 million undocumented immigrants are eligible under DACA, which allows individuals who came to the U.S. as children and meet several guidelines to apply for deferred deportation and be eligible for work authorization. Many DACA-eligible medical students want to meet the needs of their communities and have the potential to increase the physician workforce, particularly for underserved populations and in underserved areas. This issue should be studied by the AMA. Therefore, your Reference Committee recommends adoption.

(7) RESOLUTION 323 - ENSURING EQUALITY IN LOAN REPAYMENT PROGRAMS FOR MARRIED COUPLES

RECOMMENDATION:

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

HOD ACTION: Resolution 323 adopted.

Resolution 323 asks that our AMA oppose any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.

Your Reference Committee heard unanimous testimony in favor of this item and significant concern about a “marriage penalty” for married couples with significant student loans and disparate incomes. Such a penalty is not incurred by couples that co-habit but are not legally married. Therefore, your Reference Committee recommends adoption as amended.

(8) RESOLUTION 319 - PROMOTING TRANSPARENCY IN MEDICAL EDUCATION AND ACCESS TO TRAINING IN SETTINGS AFFILIATED WITH RELIGIOUS HEALTH CARE ORGANIZATIONS

RECOMMENDATION A:

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

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 319 be changed, to read as follows:

PROMOTING TRANSPARENCY IN MEDICAL EDUCATION AND ACCESS TO TRAINING

HOD ACTION: Resolution 319 adopted with change in title.

Resolution 319 asks that our AMA 1) strongly encourage medical schools and graduate medical education training programs to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and 2) work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities.

Your Reference Committee heard testimony in favor of this item and broadening its scope beyond affiliations and mergers involving religious health care organizations—hence the suggested title change. A resident’s training may be impacted by a health care facility discontinuing a particular service for financial or other reasons. Therefore, your Reference Committee recommends adoption of Resolution 319.

(9) BOARD OF TRUSTEES REPORT 25 - ABOLISH DISCRIMINATION AGAINST IMGS IN MEDICAL LICENSING REQUIREMENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 25 be amended by addition on lines 19-20, to read as follows:

3) Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 of Board of Trustees Report 25 be amended by addition and deletion, to read as follows:

4. That our AMA work with interested state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section model licensure parity model resolution as a resource.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 25 be adopted as amended.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Board of Trustees Report 25 be changed, to read as follows:

ABOLISH DISCRIMINATION IN LICENSURE OF IMGs

HOD ACTION: Board of Trustees Report 25 adopted as amended with change in title.

Board of Trustees Report 25 asks that our AMA adopt the following policy, Medical Licensure of International Medical Graduates: Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs): 1) State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations; 2) All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice; 3) Discrimination against physicians on the basis of national origin and/or the country in which they completed their medical education is inappropriate; 4) U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions; 5) State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure. It also asks that our AMA continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates; continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs; work with interested state medical societies to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section model licensure parity resolution as a resource; and that the House of Delegates policies listed in Appendix B of this report be acted upon in the manner indicated.

Your Reference Committee heard testimony largely in favor of this item. Your AMA Board of Trustees has developed an excellent report that analyzes this issue in depth and, refines AMA policy in this regard, and highlights the work of the AMA International Medical Graduates Section to provide model legislation for states seeking to address this issue. Because of the variability of training requirements in various countries, a change to Recommendation 1 (3) is suggested. Also, a minor editorial change was proposed by the IMG Section in Recommendation 4. In addition, a title change was suggested to clarify the meaning and intent of the report. Licensure of physicians is a public protection issue, and states and territories retain the right to take action against any unqualified or disreputable physicians practicing within their borders. That said, our AMA encourages parity of

licensing requirements for U.S. and international medical graduates in each state/jurisdiction. Therefore, your Reference Committee recommends adoption of BOT Report 25 as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2005 HOUSE OF DELEGATES' POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be amended by addition, to read as follows:

Council on Medical Education Report 1 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, with the exception of H-310.988, Adequate Resident Compensation, which should be retained.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Recommendation in Council on Medical Education Report 1
adopted as amended and the remainder of the report filed.**

Council on Medical Education Report 1 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 favorable testimony in favor of this item. Testimony from the Resident and Fellow Section requested that Policy H-310.988, Adequate Resident Compensation, be retained, as it encompasses resident compensation, which is broader in scope than just salary. Therefore, your Reference Committee recommends adoption of CME Report 1, with this exception.

(11) COUNCIL ON MEDICAL EDUCATION REPORT 2 - UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 2 be amended by addition on lines 19 and 20, to read as follows:

3. That our AMA encourage AMA members to be proactive in shaping Maintenance of Certification (MOC) and Osteopathic Continuous Certification by seeking leadership positions on the ABMS member boards, American Osteopathic Association specialty certifying boards and MOC Committees.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2
adopted as amended, with addition of new 6th recommendation, and the
remainder of the report filed.

6. That our AMA work with interested parties to ensure that Maintenance of Certification uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

Council on Medical Education Report 2 asks that our AMA 1) advocate that the American Board of Medical Specialties (ABMS) develop fiduciary standards for its member boards that are consistent with AMA Policy D-275.960 (4), An Update on Maintenance of Certification (MOC), Osteopathic Continuous Certification and Maintenance of Licensure, which states that our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards; 2) reaffirm Policy H-275.924 (15), Maintenance of Certification (MOC), which states that actively practicing physicians should be well-represented on specialty boards developing MOC; 3) encourage AMA members to be proactive in shaping Maintenance of Certification (MOC) by seeking leadership positions on the ABMS member boards' and MOC Committees; 4) continue to monitor the actions of professional societies regarding recommendations for modification to Maintenance of Certification; and 5) rescind Policy D-275.960 (6) (9), An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, since that has been accomplished through this report.

Your Reference Committee heard much testimony in favor of this comprehensive report, which provides an update on AMA efforts with the American Board of Medical Specialties to improve the Maintenance of Certification program. Your Reference Committee understands concerns about participation in MOC and/or MOC status potentially being used to promote policy initiatives (with punitive intent) and recommends reaffirmation of H-275.924, Maintenance of Certification, to reinforce that the MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment. The changes outlined in Appendix B of the report show how the ABMS is addressing the issues that have been raised by AMA members to reduce the administrative burden and cost of MOC, improve accountability and transparency, decrease learning redundancies, and explore a number of innovations being tested to streamline the MOC Part III high-stakes secured exam and make it relevant to practice. The report also acknowledges that the AMA will continue to work with the ABMS, the American Osteopathic Association (AOA), and their respective member boards to identify and suggest improvements to the MOC and OCC programs and ensure that MOC and OCC support physicians' ongoing learning and practice improvement. Therefore, your Reference Committee recommends adoption of Report 2 as amended.

(12) COUNCIL ON MEDICAL EDUCATION REPORT 3 - AN UPDATE ON
 MAINTENANCE OF LICENSURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 3 be amended by addition and deletion on lines 5-6, to read as follows:

b) Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based, and should be practice-specialty-specific. Accountability for physicians should be led by physicians;

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Education Report 3
adopted as amended and the remainder of the report filed.**

Council on Medical Education Report 3 asks that our AMA 1) establish the following guidelines for implementation of state MOL programs: a) Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment; b) Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based, and should be specialty-specific. Accountability for physicians should be led by physicians; c) Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences; d) Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education); e) Any MOL activity should be designed for quality improvement and lifelong learning; f) Participation in quality improvement activities, such as chart review, should be an option as an MOL activity; 2) support the FSMB Guiding Principles for MOL, which state that: a) Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice; b) Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards; c) Maintenance of licensure should not compromise patient care or create barriers to physician practice; d) The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements; e) Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.); 3) work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL; and 4) explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may be helpful tools to shape and support MOL for physicians.

Your Reference Committee heard testimony in support of this report. MOL programs will recognize activities that physicians currently use or should use for continuing professional development. Medical licensure is not based on a physician's specialty, so it should follow that any MOL educational activities should not be based on one's specialty. Using the term "practice" rather than "specialty" will help ensure that state MOL programs are more likely to be tailored to individual physician's needs and relevant to their practice. With this change, your Reference Committee recommends adoption of CME Report 2 as amended.

(13) COUNCIL ON MEDICAL EDUCATION REPORT 5 - COMPETENCY AND THE AGING PHYSICIAN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior aging/late career physicians remain able to provide safe and effective care for patients.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

2. That our AMA convene encourage organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior aging/late career physician and develop a research agenda that could guide

those interested in this field and serve as the basis for guidelines more grounded in research findings.

RECOMMENDATION C:

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

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Council on Medical Education Report 5 be changed, to read as follows:

ASSURING SAFE AND EFFECTIVE CARE FOR PATIENTS BY SENIOR/LATE CAREER PHYSICIANS

**HOD ACTION: Recommendations in Council on Medical Education Report 5
adopted as amended with change in title and the remainder filed.**

Council on Medical Education Report 5 asks that our AMA 1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that aging/late career physicians remain able to provide safe and effective care for patients; 2) encourage organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the aging/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings; and 3) rescind Policy D-275.959, Competency and the Aging Physician, since this directive has been accomplished through this report.

Your Reference Committee heard strong support for CME Report 5, which addresses a complex and sensitive topic. Many organizations expressed strong interest in working with our AMA to develop preliminary guidelines for assessment of the senior/late career physician, and to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. Therefore, your Reference Committee recommends that CME Report 5 be adopted as amended.

(14) COUNCIL ON MEDICAL EDUCATION REPORT 6 - AMERICAN BOARD OF MEDICAL SPECIALTIES SHOULD ADHERE TO ITS MISSION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 6 be amended by addition and deletion, to read as follows:

That our American Medical Association (AMA) work with the American Board of Medical Specialties (ABMS) to ensure that ABMS member boards avoid attempts at restricting the legitimate scope of practice of board-certified physicians ~~who have received appropriate training and have demonstrated competency in additional areas, particularly if such restrictions could decrease access to health care services for specific patient populations. This is not meant to restrict the ability of ABMS member boards from deliberating on and issuing guidelines on the legitimate scope of practice within that board's specialty.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 6 be adopted as amended.

**HOD ACTION: Recommendation in Council on Medical Education Report 6
adopted as amended.**

That our American Medical Association (AMA) work with the American Board of Medical Specialties (ABMS) to ensure that ABMS member boards avoid attempts at restricting the legitimate scope of practice of board-certified physicians.

Council on Medical Education Report 6 asks that our AMA work with the American Board of Medical Specialties (ABMS) to ensure that ABMS member boards avoid attempts at restricting the legitimate scope of practice of board-certified physicians who have received appropriate training and have demonstrated competency in additional areas, particularly if such restrictions could decrease access to health care services for specific patient populations.

Your Reference Committee heard limited but supportive testimony on this item. The Council on Medical Education noted in its testimony that this could be a larger issue going forward, such that the AMA's developing policy on this issue is warranted. A friendly amendment was offered by the plastic surgery caucus, as noted. Your Reference Committee concurs and recommends adoption as amended.

**(15) COUNCIL ON MEDICAL EDUCATION REPORT 8 - MEANINGFUL
ACCESS TO ELECTRONIC HEALTH RECORDS FOR MEDICAL
STUDENTS**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 in Council on Medical Education Report 8 be adopted by addition on lines 23-27, to read as follows:

5. That our AMA work with the Liaison Committee for Medical Education (LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 8 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Education Report 8
adopted as amended and the remainder of the report filed.**

Council on Medical Education Report 8 asks that our AMA 1) reaffirm Policy H-315.969, Medical Student Access to Electronic Health Records, which recognizes the benefits of medical students' access to electronic health record systems as part of their clinical training; 2) support medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients' electronic health records (EHRs), with appropriate supervision, as was the case with paper charting; 3) (1) research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (2) based on the research—including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education—determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs; 4) encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision; and 5) work with the Liaison Committee (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the

nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care.

Your Reference Committee heard testimony, live and online, in strong support of this report, which provides an update on the current level of student involvement with EHRs in undergraduate and graduate medical education. There is a need to explore best practices and opportunities to assure that students and residents have ample opportunities to have access to and meaningful experiential clinical experiences with EHRs. Given the testimony in favor of this item, your Reference Committee recommends adoption of CME Report 8 as amended.

(16) RESOLUTION 304 - ADDRESSING THE INCREASING NUMBER OF UNMATCHED MEDICAL STUDENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 304 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 304 be amended by substitution, to read as follows:

RESOLVED, that our AMA discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 304 be adopted as amended.

HOD ACTION: Resolution 304 adopted as amended.

Resolution 304 asks that our AMA 1) study, in collaboration with the Association of American Medical Colleges and the American Osteopathic Association, the common reasons for failures to match; and 2) study potential pathways for reengagement in the medical field for applicants to the National Resident Matching Program who fail to match.

Your Reference Committee heard testimony in support of the principle of Resolution 304. The resolution author noted that this problem is becoming more dire, with the continued growth in enrollments in medical schools as well as the imminent unification of the accreditation systems for allopathic and osteopathic residency programs. Indeed, this was the topic of a Section on Medical Schools' educational session at this Annual Meeting, to ensure that medical students obtain needed guidance and counseling pre-Match and assistance with any post-Match problems, including advice on alternative career options, as needed. The Council on Medical Education voiced support for this item but with the substitution of a new Resolve 2, to ensure adequate collaboration with other key stakeholder organizations. Other testimony called for the addition of the National Resident Matching Program to Resolve 1, to ensure their involvement in any study of Match issues. Your AMA will continue to study and closely monitor this issue—through the efforts of the Council on Medical Education and Section on Medical Schools, among others—to

ensure the highest possible return on the nation's investment in our future medical workforce. Therefore, your Reference Committee recommends adoption as amended.

(17) RESOLUTION 307 - POLICY AND ADVOCACY OPPORTUNITIES FOR MEDICAL STUDENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 307 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 307 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support and encourage internal institutional, state and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 307 be adopted as amended.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 307 be changed, to read as follows:

POLICY AND ADVOCACY OPPORTUNITIES FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS

HOD ACTION: Resolution 307 adopted as amended with change in title.

Resolution 307 asks that our AMA (1) establish health policy and advocacy elective rotations based in Washington, DC for medical students; and (2) support and encourage internal, state, and specialty organizations to offer health policy and advocacy opportunities for medical students.

Your Reference Committee heard unanimous testimony in favor of this item. Students value these types of opportunities for the professional experience, and the AMA can benefit from the leadership skills that students gain. There also was significant testimony about the value of expanding these programs to residents and fellows, and to reflect the types of organizations (including institutions) that could sponsor such programs. Therefore, your Reference Committee recommends adoption as amended.

(18) RESOLUTION 308 - REDUCING THE FINANCIAL AND EDUCATIONAL COSTS OF RESIDENCY INTERVIEWS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 308 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of ~~consider~~ the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with ~~residency~~ such interviews.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 308 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 308 be changed, to read as follows:

REDUCING THE FINANCIAL AND EDUCATIONAL COSTS OF RESIDENCY/FELLOWSHIP INTERVIEWS

HOD ACTION: Resolution 308 adopted as amended with change in title.

Resolution 308 asks that our AMA consider the following strategies to address the high cost of interviewing for residency: a) establish a method of collecting data on interviewing costs for medical students of all specialties for study, and b) support further study of residency interview strategies aimed at mitigating costs associated with residency interviews.

Your Reference Committee heard positive testimony on this item. The resolution's authors noted that costs for interviews are skyrocketing, and students are applying more broadly than ever before, particularly in more competitive specialties. Some individuals may apply to over 100 programs, visit 20, and spend \$10,000 on travel costs. In its testimony, the Council on Medical Education expressed its support for these sentiments and the principle behind the resolution, but noted that our AMA alone may not be the appropriate organization to study these costs and strategies to mitigate them, and suggested revised language, so that the Association may work with other stakeholders to accomplish these tasks in a more effective and efficient manner. Finally, testimony noted that such costs apply to interviews for fellowships as well, so a language and title change is recommended to reflect this aspect. Accordingly, your Reference Committee recommends adoption of Resolution 308 as amended.

(19) RESOLUTION 310 - MITIGATION OF PHYSICIAN PERFORMANCE METRICS ON TRAINEE AUTONOMY AND EDUCATION

RECOMMENDATION:

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

MITIGATION OF PHYSICIAN PERFORMANCE METRICS ON TRAINEE EDUCATION

RESOLVED, That our AMA ask the Accreditation Council for Graduate Medical Education and other organizations to use data to evaluate the impact of supervising physicians' performance metrics on trainees' learning experience.

HOD ACTION: Substitute Resolution 310 adopted.

Resolution 310 asks that our AMA assess ways to mitigate the negative effects of physician performance metrics on trainee autonomy and clinical experience during residency and fellowship training.

Your Reference Committee heard limited but favorable testimony on this item. To ensure the highest quality of medical practice, resident/fellow physicians need to obtain adequate clinical experiences in supervised settings so that they are ready to practice independently upon graduation from residency. The Council on Medical Education was supportive of the resolution, but called for substitute language, due to variation in residency/fellowship programs. For those programs accredited by the Accreditation Council for Graduate Medical Education, the applicable ACGME Residency Review Committee would be the appropriate entity to ensure trainees' experiences are not negatively affected by performance metrics. This would not be the case, however, for non-ACGME-accredited fellowship programs. Therefore, your Reference Committee recommends adoption of Substitute Resolution 310.

(20) RESOLUTION 313 - HUMAN TRAFFICKING REPORTING AND EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 313 be amended by deletion of the first resolve.

~~RESOLVED, That our American Medical Association work with the Association of American Medical Colleges and the Liaison Committee on Medical Education on the formal education of medical professionals on identifying and managing victims of human trafficking as they enter the healthcare system that will cover the role of the medical professional in: i) the social impact of human trafficking, ii) screening and identifying victims, iii) first response to identified victims, iv) communication and trust building skills with victims, v) understanding the effects of trauma on the brain including PTSD and trauma bonding, vi) current state and federal laws in place for victims, vii) visa status for victims, and viii) community and national resources to help victims receive proper care during the process of reintegration into society; and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 313 be amended by addition and deletion, to read as follows:

~~RESOLVED, that our AMA help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate local law enforcement authorities and national hotlines in consultation with their institutional guidelines in order to provide a conduit to resources to address the victim's medical, legal and social needs.~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 313 be adopted as amended.

HOD ACTION: Resolution 313 adopted as amended.

Resolution 313 asks that our AMA 1) work with the Association of American Medical Colleges and the Liaison Committee on Medical Education on the formal education of medical professionals on identifying and managing victims of human trafficking as they enter the healthcare system that will cover the role of the medical professional in: i) the social impact of human trafficking, ii) screening and identifying victims, iii) first response to identified victims, iv) communication and trust building skills with victims, v) understanding the effects of trauma on the brain

including PTSD and trauma bonding, vi) current state and federal laws in place for victims, vii) visa status for victims, and viii) community and national resources to help victims receive proper care during the process of reintegration into society; and 2) help encourage the education of physicians about how to report cases of suspected human trafficking to local law enforcement authorities and national hotlines in consultation with their institutional guidelines in order to provide a conduit to resources to address the victim's medical, legal and social needs.

Your Reference Committee heard unanimous testimony in support of increased awareness among physicians of human trafficking, a \$32 billion global industry, but there were significant concerns that the actions in the first resolve were outside the purview of physicians, and that this resolve constitutes a curricular mandate. Therefore, your Reference Committee recommends adoption as amended.

(21) RESOLUTION 314 - MAINTENANCE OF CERTIFICATION AND
CONTINUING EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 314 be adopted in lieu of Resolution 314.

RESOLVED, That our AMA encourage medical specialty societies' leadership to work with the ABMS, and their member specialty boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-275.924 be amended, to read as follows:

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. 11. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care. 12. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. 13. MOC should be used as a tool for continuous improvement. 14. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment. 15. Actively practicing physicians should be well-represented on specialty boards developing MOC. 16. MOC activities and measurement should be relevant to clinical practice. 17. The MOC process should not be cost prohibitive or present barriers to patient care. 18. Any assessment tests should be used to guide physicians' self-directed CME study, and should never be punitive. 19. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner so physicians know what they got wrong and why, and utilize the information in a beneficial manner. 20. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Policy H-274.924 be adopted as amended.

**HOD ACTION: Substitute Resolution 314 adopted and Policy H-274.924
amended with addition of 18-20:**

18. Any assessment should be used to guide physicians' self-directed CME study. 19. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner. 20. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

Resolution 314 asks that AMA Policy H-275.924, Principles on Maintenance of Certification (MOC), be amended by addition to include the following:

Board Certification once attained, should be "lifelong" for physicians; Testing organizations' Boards should be constituted with, at a minimum, 50% of their members being physicians engaged in active practice - defined as actively seeing patients for more than 50% of their professional time in practice; Minimum CME requirements should be reasonably set and used as a replacement for the current proposed modules, enabling physicians to self-direct their learning; Any assessment tests should be used to guide physicians' self-directed CME study, and should never be punitive, thereby eliminating the need for a "secure exam"; Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner so physicians know what they got wrong and why, and utilize the information in a beneficial manner; There should be multiple options for how an assessment could be structured to accommodate different learning styles. The resolution also asks that our AMA directly communicate all of the Principles in AMA Policy H-275.924, as amended, to the American Board of Medical Specialties (ABMS), and all member specialty boards, and actively seek their support thereof; that our AMA work with the ABMS and collectively become actively engaged in the monitoring of board/testing stakeholder

organizations to assure they are supporting physician practices not impeding it; that our AMA encourage state medical societies' leadership to work with the ABMS, and their member specialty boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members; and that our AMA communicate its belief that American Board of Internal Medicine Foundation funds should be mobilized for use by the physicians that funded it.

Your Reference Committee heard mixed testimony regarding Resolution 314. Our AMA has extensive policy to support the principles of MOC, and the Council on Medical Education is working with the ABMS and its member boards to streamline the MOC Part III high-stakes secured exam and make it relevant to practice. CME Report 2, Update on Maintenance of Certification and Osteopathic Continuous Certification, provides an update on a number of innovations being tested by the ABMS member boards to improve this process. The report also reviews how the member boards are working with medical specialty societies to develop educational curricula and provide resources to support physician professional development. The Council will continue to work with the ABMS, the American Osteopathic Association, and their respective member boards to identify and suggest improvements to the MOC and OCC programs and ensure that MOC and OCC support physicians' ongoing learning and practice improvement. Your Reference Committee therefore recommends that Substitute Resolution 314 be adopted in lieu of Resolution 314.

(22) RESOLUTION 315 - OBESITY EDUCATION
 RESOLUTION 326 - OBESITY EDUCATION IN MEDICAL SCHOOLS
 AND RESIDENCY PROGRAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 315 be adopted in lieu of Resolution 326.

OBESITY EDUCATION

RESOLVED, That our American Medical Association (AMA) study and report back on the current state of obesity education in medical schools.

RESOLVED, That our AMA, through this report, identify organizations that currently provide educational resources/toolkits regarding obesity education for physicians in training.

HOD ACTION: Substitute Resolution 315 adopted in lieu of Resolution 326.

OBESITY EDUCATION

RESOLVED, That our American Medical Association encourage medical school accrediting bodies to study and report back on the current state of obesity education in medical schools.

RESOLVED, That our AMA, through this report, identify organizations that currently provide educational resources/toolkits regarding obesity education for physicians in training and, in consultation with relevant specialty organizations and stakeholders, identify gaps in obesity education in medical schools and submit recommendations for addressing those gaps.

Resolution 315 asks that our AMA 1) with the AAMC, COCA, the LCME and other interested parties, study and report back on the current state of obesity education in medical schools; 2) with the AAMC, COCA, the LCME, and other interested parties, research and define a minimum recommended knowledge base for a physician in training to be consider competent in regards to obesity; and 3) with appropriate interested parties, create a toolkit regarding obesity education for physicians in training.

Resolution 326 asks that our AMA 1) create a report on the current state of obesity education in medical schools; 2) research and define a minimum recommended knowledge base for a physician in training to be considered competent in the prevention, diagnosis and treatment of disease; and 3) create a model curriculum regarding obesity for medical schools to ensure that all individuals receive the same standard of care, regardless of their weight.

Your Reference Committee heard testimony in support of educating physicians on the topic of obesity. AMA policy recognizes obesity as a disease and as a major public health problem. However, many medical societies, such as the American Academy of Pediatrics, already make toolkits available to physicians. Furthermore, our AMA (Council on Medical Education and Section on Medical Schools) generally oppose curricular mandates. Therefore, your Reference Committee recommends Substitute Resolution 315 be adopted in lieu of Resolutions 315 and 326.

(23) RESOLUTION 324 - PROPOSING CHANGES TO PUBLIC SERVICE LOAN FORGIVENESS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 324 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; ~~leaving any accrued interest the responsibility of the borrower~~; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 324 be adopted as amended.

HOD ACTION: Resolution 324 adopted as amended.

Resolution 324 asks that our AMA (1) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (2) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be equal to the principal amount borrowed; and (3) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.

Your Reference Committee heard testimony in favor of this item. The author of the resolution noted that the Department of Education currently offers a number of loan repayment options, each with specific advantages and disadvantages, but these different options are in danger of being consolidated into one plan through the administrative rulemaking process, which is under way. This could have negative repercussions for nontraditional medical students. Accordingly, it is timely that this issue is being considered now, and wise for our AMA to have policy on this topic. Other testimony raised concerns about Resolve 2 and the amount of "skin in the game" for a given loan recipient. Your Reference Committee believes its proffered revisions would address these concerns and therefore recommends adoption of Resolution 324 as amended.

(24) RESOLUTION 301 - ALERTING PHYSICIANS TO DEADLINES FOR MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 301 be referred.

HOD ACTION: Resolution 301 adopted.

Resolution 301 asks that our AMA 1) continue to work with the American Board of Medical Specialties (ABMS) to ensure that physicians are clearly informed of the maintenance of certification requirements for their specific board and the timelines for accomplishing those requirements; and 2) encourage the ABMS and its member boards to develop a system to actively alert physicians to the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

Your Reference Committee heard mixed testimony on this item. It is important that MOC participants be informed about the due dates of the multi-stage requirements of MOC. However, ABMS standards state that the individual ABMS member boards have the responsibility of using “reasonable means” to inform diplomates of the timelines for accomplishing specific MOC requirements, and in most cases they provide notifications. The Council on Medical Education will explore this issue and provide an update in its next mandated update report to the House of Delegates. Therefore, your Reference Committee recommends that Resolution 301 be referred for further study.

(25) **RESOLUTION 302 - RE-EVALUATING KNOWLEDGE ASSESSMENT IN MAINTENANCE OF CERTIFICATION**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 302 be referred.

HOD ACTION: Resolution 302 adopted.

Resolution 302 asks that our AMA work with the American Board of Medical Specialties to streamline and improve the Cognitive Expertise (Part III) component of Maintenance of Certification, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

Your Reference Committee heard mixed testimony regarding this item. As noted in CME Report 2, Update on Maintenance of Certification and Osteopathic Continuous Certification, the Council on Medical Education has been working with the ABMS and its member boards to explore alternatives to the secure, high-stakes examination for assessing knowledge and cognitive skills. The Council will continue to explore this issue and provide an update in their next mandated update report to the House of Delegates. Therefore, your Reference Committee recommends that Resolution 302 be referred for further study.

(26) **RESOLUTION 312 - MODEL GUIDELINES FOR EXPANSION OF RESIDENCY PROGRAMS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 312 be referred.

HOD ACTION: Resolution 312 referred.

Resolution 312 asks that our AMA facilitate a working group that includes the International Medical Graduates Section, Medical Student Section, Resident and Fellow Section, Section on Medical Schools, Council on Medical Education and other stakeholders, with the charge for creating model guidelines for expansion of existing residency programs, with funding support from non-federal donors.

Your Reference Committee heard testimony in favor of referral of Resolution 312. The Council on Medical Education described its work on a report for the I-15 meeting, stemming from referral of Resolution 931-I-14, which will summarize existing funding streams for graduate medical education, provide examples of and new models for alternative funding sources, and outline principles to ensure quality of training and patient safety. Because this work is already in process, and can be modified to reflect the intent of Resolution 312, your Reference Committee recommends referral.

(27) RESOLUTION 318 - MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 318 be referred.

HOD ACTION: Resolution 318 referred.

Resolution 318 asks that our AMA 1) congratulate the American Board of Medical Specialties (ABMS) and its member Boards on their century of service to our profession and our patients; and 2) engage the ABMS and member Boards to conduct an independent, external review process to examine the performance and impact of Board policies, procedures, organizational structure and governance.

Your Reference Committee heard limited testimony regarding this resolution. It is not our AMA's role to oversee the ABMS member boards, and as such our AMA should not be involved in any process to review ABMS member board policies, procedures, organizational structure, and governance processes. There are also concerns about an external reviewer outside the medical profession; this type of action is not warranted at this time, and furthermore, this is the purview of the ABMS. The Council on Medical Education will continue to explore this issue and provide an update in its next mandated update report to the House of Delegates. Therefore, your Reference Committee recommends that Resolution 318 be referred for further study.

(28) RESOLUTION 321 - VALUE OF RESIDENTS AND FELLOWS TO THE
HEALTH CARE SYSTEMRESOLUTION 327 - ACHIEVING TRANSPARENCY THROUGH
GRADUATE MEDICAL EDUCATION FUNDINGRESOLUTION 328 - EVALUATION OF RESIDENT AND FELLOW
COMPENSATION LEVELS

RESOLUTION 329 - PRINCIPLES OF GME FUNDING REFORM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 321, 327, 328 and 329 be referred.

**HOD ACTION: Resolve 1 of Resolution 321 adopted, Resolve 2 of Resolution
321 referred; Resolutions 327, 328 and 329 referred.**

Resolution 321 asks that our AMA 1) advocate that resident and fellow trainees should not be financially responsible for their training; and 2) evaluate and work to establish consensus regarding the appropriate value of resident and fellow services, and address this in upcoming reports regarding graduate medical education financing.

Resolution 327 asks that our AMA 1) reaffirm D-305.967 and continue to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions; 2) support combining Indirect Graduate Medical Education into the Direct Graduate Medical Education payments into a single, transparent funding stream; 3) support that Medicare's Graduate Medical Education funding be a per-resident federal allocation that is adjusted according to solely geographic measures, such as cost-of-living; and 4) support that the payment of Graduate Medical Education funding be directed to the designated residency GME office, in lieu of the hospital system, to be allocated across the department(s), sites and other specialties to provide comprehensive training.

Resolution 328 asks that our AMA 1) develop recommendations for appropriate protections and increases to resident and fellow compensation and benefits with input from residents, fellows, and other involved parties including residency and fellowship programs; 2) advocate that resident and fellow trainees should not be financially responsible for their training; and 3) evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services, and address this in upcoming reports regarding graduate medical education financing.

Resolution 329 asks that our AMA 1) supports that federal funding for Graduate Medical Education should be based on the actual costs to train and educate a resident/fellow (including but not limited to salary and benefits and institutional support for training and education) including yearly adjustments for geographic and inflation-based cost-of-living; 2) supports that the allocation of Graduate Medical Education funds within an institution should be transparent and accountable to all stakeholders; 3) support that federal funding for Graduate Medical Education should strive to meet the health needs of the public including but not limited to size of the training program, geographic distribution, and specialty mix; 4) support that federal funding for Graduate Medical Education from the Centers for Medicare/Medicaid Services or any federal successors should be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payer system; and 5) support additional federal funding for Graduate Medical Education that provides flexibility for innovation in training and education above and beyond current levels of funding.

Your Reference Committee heard mixed testimony on these four items, which are inter-related and cover similar topics. This highlights the complexity of the issues they raise and the potential unintended consequences they may present (i.e., a “slippery slope” that moves the dialogue on GME away from an educational focus to a service and bottom-line focus). It is inarguable that the substantial and still rising debt load on graduating medical students and resident/fellow physicians is reaching crisis proportions, and our AMA should formulate a feasible, long-range solution that takes into account all the moving parts of this complex puzzle. The first step would be to quantify the extent of the problem, and the true value of resident/fellow services (one estimate cited in testimony pegs the number at approximately \$150,000 per year, according to a fall 2014 *Health Affairs* study). Adoption of policy through these resolutions, three of which were immediately forwarded to this Annual Meeting, may ultimately be less helpful than a more reasoned, circumspect approach, through referral to the appropriate AMA organ for a full review and subsequent report. Indeed, a considerable amount of the testimony on these items urged referral, including that of the Council on Medical Education. Due to the many questions raised in consideration of these items, and uncertainty as to how these broad changes might impact GME funding and related issues, your Reference Committee believes that these issues must be studied in more detail before being adopted as new policy, and therefore recommends referral.

(29) RESOLUTION 330 - TELEMEDICINE IN GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 330 be referred.

HOD ACTION: Resolution 330 referred.

Resolution 330 asks that our AMA 1) advocate for educating resident and fellow physicians during their training on the use of telehealth technology in their future practices, and 2) study the barriers to optimizing the use of telehealth technology for the purposes of tele-education and specifically tele-precepting in Graduate Medical Education and the solutions to overcoming these barriers.

Your Reference Committee heard testimony in favor of studying the barriers to optimizing the use of telehealth technology for the purposes of tele-education and, especially, tele-precepting in graduate medical education, but also heard testimony opposed to creating a curricular mandate in GME on the subject. In addition, aspects of this topic are outside the purview of the AMA, such that collaboration with an outside stakeholder(s) may be appropriate. Therefore, your Reference Committee recommends referral.

(30) RESOLUTION 309 - MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 309 not be adopted.

HOD ACTION: Resolution 309 referred.

Resolution 309 asks that our AMA advocate for a moratorium on the maintenance of certification requirements of all medical and surgical specialties until it has been reliably shown that these programs significantly improve patient care.

Your Reference Committee heard limited but mixed testimony on this item. The process of MOC contains many elements, and suspension of the entire program would include removal of components such as continuing medical education and the fulfillment of licensing requirements. Also, a moratorium would affect all 24 ABMS member boards, even though a number of these boards are not the source of the problem. Further, as noted in the testimony, there are studies that show the process can and should be improved, but “reliably shown” and “significantly improve patient care” are terms that are too vague to provide appropriate direction for ongoing MOC research and process improvement. Therefore, your Reference Committee recommends that Resolution 309 not be adopted.

(31) RESOLUTION 317 - PROTECT PHYSICIAN CERTIFICATION AND LICENSURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 317 not be adopted.

HOD ACTION: Resolution 317 not adopted.

Resolution 317 asks that our AMA seek legislation that would prohibit hospitals, all employers, regulatory agencies, all third-party payers, insurers, Medicare, Medicaid and other entities, from requiring physicians to participate in prescribed corporate programs including Maintenance of Certification or expiration of time-limited Maintenance of Certification, and from discriminating against physicians economically through various fee schedules.

Your Reference Committee heard limited mixed testimony regarding this resolution. Our AMA has extensive policy opposing mandated board certification, recertification, specialty recertification, and maintenance of certification for licensure, reimbursement, credentialing, network participation, or employment. Seeking federal legislation to enforce existing policy would divert AMA focus and resources away from strategic issues such as funding of graduate medical education, improving public health, standards of care in telemedicine, coordinated care and new delivery models, medical liability reform, and expanding coverage for the uninsured. Therefore, your Reference Committee recommends that Resolution 317 not be adopted.

(32) RESOLUTION 320 - POST-ACUTE AND LONG-TERM CARE EDUCATION REQUIREMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 320 not be adopted.

HOD ACTION: Resolution 320 adopted as amended.

RESOLVED, That our American Medical Association support a mandatory minimum exposure to the post-acute and long-term care setting in undergraduate and graduate medical education.

Resolution 320 asks that our AMA support a mandatory minimum exposure to the post-acute and long-term care setting in undergraduate and graduate medical education.

Your Reference Committee heard limited testimony in opposition to this item, despite its importance as a topic area, because it constitutes a curricular mandate, which the AMA generally opposes. Your Reference Committee therefore recommends that our AMA not adopt Resolution 320.

(33) RESOLUTION 322 - BOARD OF MEDICINE SANCTIONS AND FINES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 322 not be adopted.

HOD ACTION: Resolution 322 not adopted.

Resolution 322 asks that our AMA work with the Federation of State Medical Boards to study the various sanctions, fines, and monitoring procedures applied on a state-by-state basis to physicians under investigation and/or disciplinary action.

Your Reference Committee heard unanimous testimony in opposition of this item (with the exception of the resolution's author). Testimony reflected that the results of such a study might be interesting, but it is unclear what purpose these data would serve. This work might also be seen as an attempt to usurp state roles in this regard, and the AMA has policy against national licensure. Therefore, your Reference Committee recommends that Resolution 322 not be adopted.

(34) RESOLUTION 325 - BROADEN CONFLICT OF INTEREST DISCLOSURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 325 not be adopted.

HOD ACTION: Resolution 325 not adopted.

Resolution 325 asks that our AMA work with the Accreditation Council for Continuing Medical Education and the American Osteopathic Association pertaining to any continuing medical education programming to broaden their required conflict of interest disclosure and management of conflict of interest to include all forms of funding, including, but not limited to: employers, corporations, drug companies, governmental entities (e.g., National Institutes of Health), foundations, speakers' bureaus, speaking engagements, and universities.

Your Reference Committee heard nearly unanimous testimony in opposition to this item (with the exception of the author). Testimony was appreciative of the intent of this item, and appropriate reporting of conflict is needed, but it was strongly felt that this resolution was overly broad, such that physicians might be loath to undertake a CME program. Further, data on funding from many of the entities named in the resolution are already publicly available. Therefore, your Reference Committee recommends that Resolution 325 not be adopted.

(35) RESOLUTION 306 - INCLUDING MILITARY HISTORY AS PART OF STANDARD HISTORY TAKING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-295.874 be reaffirmed in lieu of Resolution 306.

HOD ACTION: Policy H-295.874 reaffirmed in lieu of Resolution 306.

Resolution 306 asks that our AMA (1) encourage the universal inclusion of military history in the standard history taking of all adults in civilian healthcare settings; and (2) support the addition of military history training to undergraduate, graduate, and continuing medical education and the continued refinement of existing screening resources.

Your Reference Committee heard mixed testimony on this item. There was general support for physicians asking about a patient's military history, and a military history is viewed as an element of a good social history. Significant

questions were raised, however, about whether it was necessary to develop policy on this matter. For this reason, your Reference Committee recommends reaffirmation of Policy H-295.874.

Policy recommended for reaffirmation:

H-295.874 Educating Medical Students in the Social Determinants of Health and Cultural Competence
 Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

(36) **RESOLUTION 311 - SELECTING RESIDENTS TO BETTER REFLECT PATIENT DIVERSITY**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-350.960, H-350.969, and H-350.970 be reaffirmed in lieu of Resolution 311.

HOD ACTION: Policy H-350.960, H-350.969 and H-350.970 reaffirmed in lieu of Resolution 311.

Resolution 311 asks that our AMA advocate that the criteria used for selecting residents have greater emphasis and consideration placed on qualitative and demographic characteristics of resident candidates in order to train a more diverse and culturally, competent physician workforce that better reflects the diversity of the U.S. patient population.

Your Reference Committee heard testimony in favor of the sentiment of this item, but that the residency selection process is too late in the pipeline to have any real impact on the diversity of the physician workforce. Residency program directors cannot be responsible for increasing the diversity of the physician workforce single-handedly, as they can only select from the product before them; further, the structure of the Match doesn't ensure that the applicant they want is the one they will get. Efforts in the premedical arena are where work to increase physician diversity should be focused (for example, through the AMA's Doctors Back to School program). The AMA already has significant policy in this regard, so your Reference Committee recommends reaffirmation of these policies in lieu of Resolution 311.

Policy recommended for reaffirmation:

H-350.960 Underrepresented Student Access to US Medical Schools

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

H-350.969 Medical Education for Members in Underserved Minority Populations

Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the

participation of under-represented minorities as investigators, trainees, reviewers, and subjects in peer review biomedical research at all levels.

H-350.970 Diversity in Medical Education

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

REPORT OF REFERENCE COMMITTEE D

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - CSAPH
SUNSET REVIEW OF 2005 HOUSE POLICIES

RECOMMENDATION:

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

HOD ACTION: Recommendations in Council on Science and Public Health Report 1 adopted and the remainder of the report filed.

In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on the disposition of the House policies from 2005 that were assigned to it. The CSAPH's recommendations on policies are presented in the Appendix to this report. The CSAPH recommends that the policies of the House of Delegates that are listed in the Appendix to this report be acted upon in the manner indicated in the Appendix.

Your Reference Committee heard no testimony regarding CSAPH Report 1 and is confident in the decisions made by the CSAPH. Your Reference Committee therefore recommends adoption of CSAPH Report 1.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 - BAN ON SUPER MAGNETIC TOYS AS A CHOKING HAZARD AND GASTROINTESTINAL HAZARD TO CHILDREN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 2 be adopted and that the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 2 adopted and the remainder of the report filed.

Resolution 411-A-14 introduced by American Medical Group Association and referred by the House of Delegates asked:

That our American Medical Association (AMA) work with the Consumer Product Safety Commission (CPSC) and other relevant governmental agencies to prohibit the sale of neodymium magnetic balls whose flux, or magnetic, strength index is greater than 50 and also who fail the CPSC's cylinder tests for choking hazards.

The recommendation reads that given the Resolve in Resolution 411-A-14 has been accomplished, the CSAPH recommends that Resolution 411-A-14 not be adopted and the remainder of the report filed.

Your Reference Committee heard no testimony regarding this report and is confident in the recommendations from the CSAPH. The Consumer Product Safety Commission issued a rule last year on this very issue, thereby accomplishing the resolve. Therefore, your Reference Committee recommends that the recommendations in CSAPH 2 be adopted.

(3) RESOLUTION 423 - SUPPORT OF MANDATORY PROTECTIVE HEADGEAR (HELMETS) IN THE SPORT OF GIRLS/WOMEN'S LACROSSE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 423 be adopted with a change in title.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 423 be changed to read as follows:

SUPPORT OF PROTECTIVE HEADGEAR (HELMETS) IN THE SPORT OF GIRLS'/WOMEN'S LACROSSE

HOD ACTION: Resolution 423 adopted with a change in title.

Resolution 423 asks that our AMA support requiring approved protective headgear for all athletes participating in the sport of girls'/women's lacrosse.

Your Reference Committee received significant favorable testimony on the need for players, regardless of gender, to wear approved, protective headgear to prevent concussions. The resolution stimulated debate on whether evidence conclusively demonstrates that helmet use prevents concussions. Some testimony asked for referral. Your Chair noted that US Lacrosse, a national governing body, submitted a letter for testimony requesting that our AMA defer passage of Resolution 423 until it can be amended to consider the changes in women's lacrosse headgear standard development. US Lacrosse, NCAA and the NFHS are currently working to determine the appropriate rule language and an implementation timetable. Your Reference Committee recognizes the concerns presented by testimony. However, given that overwhelming testimony was favorable to requiring appropriate headgear for all lacrosse athletes, your Reference Committee recommends adoption and suggests the title be changed, keeping in line with the language in the resolve.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - CONCUSSION AND YOUTH SPORTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of CSAPH Report 3 be amended by addition and deletion to read as follows:

- (1) Our AMA promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other physical sports-related activity without the written approval of a licensed physician (MD or DO) or a designated member of the physician-led care team licensed health care professional, whose scope of practice includes being who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) and health care professionals or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.
- (2) Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; and (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends the recommendations in CSAPH Report 3 be adopted as amended and the remainder of the report be filed.

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

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The following resolutions were referred by the House of Delegates at A-14:

- Resolution 401, "Heading in Youth Soccer,"
- Resolution 410, "Evaluating and Reducing the Risk of Youth Sports Concussion,"
- Resolution 412, "Management of Concussion Guidelines"

The CSAPH deemed that a comprehensive report summarizing the epidemiology, risks, and potential consequences of concussion in youth sports would provide a useful resource to help educate physicians on this important and evolving topic. Recommendations in the report consolidate, expand, or reaffirm numerous AMA policies relevant to sports-related concussion, which are listed in Appendix A.

Your Reference Committee heard supportive testimony for this report, some of which thanked the CSAPH for an excellent report. An amendment was offered to go beyond just physicians to include allied health care professionals whose scope of practice includes such training. Additionally, an amendment was offered in support of preseason testing of each individual in order to collect baseline data for future use if necessary. Your Reference Committee agreed that these amendments would strengthen the original recommendations and therefore recommends adopting CSAPH 3 as amended.

(5) RESOLUTION 407 - ENCOURAGING PROTOCOLS TO ASSIST WITH THE MANAGEMENT OF OBESE PATIENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 407 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage health care providers professionals to learn about techniques and devices to prevent potential injury and to provide safe and effective care for obese patients with obesity.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 407 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 407 be changed to read as follows:

ENCOURAGING PROTOCOLS TO ASSIST WITH THE MANAGEMENT OF PATIENTS WITH OBESITY DURING POSITIONING AND TRANSPORTATION

HOD ACTION: Resolution 407 adopted as amended with a change in title.

Resolution 407 asks that our AMA encourage health care providers to learn about techniques and devices to prevent potential injury and to provide safe and effective care for patients with obesity.

Your Reference Committee heard favorable testimony for the efforts that may prevent injury of health care professionals and of patients with obesity during positioning and transportation. Much testimony also highlighted the importance of using people first language by stating “patients with obesity,” not “obese patients”. Your Reference Committee recommends the title be changed to reflect the intent of the resolution.

(6) RESOLUTION 406 - INCREASING TOY GUN SAFETY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 406 be adopted.

RESOLVED, That our American Medical Association (AMA) encourage toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns.

RESOLVED, That our AMA encourage parents to increase their awareness of toy gun ownership risks.

HOD ACTION: Substitute Resolution 406 adopted.

Resolution 406 asks that our AMA (1) support legislation related to the safety of toy guns to strengthen current laws related to the manufacture of toy guns so that the orange tip cannot be easily removed or covered and (2) encourage community organizations to educate parents, children, educators, and other stakeholders about safe play with toy weapons.

Your Reference Committee heard testimony primarily in support of Resolution 406. Testimony supported education around increasing toy gun safety, but not legislation. A friendly amendment was posed to amend the language of the resolution, to encourage responsibility among toy gun manufacturers as well as parents. Your Reference Committee agreed that the amended language was more encompassing of the testimony as well as the intent of the resolution and therefore recommends adoption of the substitute resolution.

(7) RESOLUTION 413 - AIRCRAFT RESTRAINTS ON SMALL CHILDREN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-45.989 be amended by addition, to read as follows:

H-45.989 Child Safety Restraint Use in Aircraft
 Our AMA supports (1) the use of and education about appropriate restraint systems for all children on all commercial airline flights; and (2) working with the Federal Aviation Administration, International Air Transport Association and other appropriate aviation regulators to establish criteria for appropriate child restraint systems.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-45.989 be adopted in lieu of Resolution 413.

HOD ACTION: HOD Policy H-45.989 adopted as amended in lieu of Resolution 413.

Resolution 413 asks that our AMA (1) support and encourage public education and legislation promoting the use of age- and weight-appropriate child safety restraints on airplanes and (2) reaffirm and implement existing AMA Policy H-45.989 Child Safety Restraint Use in Aircraft, which directs the AMA to: support (a) the use of appropriate

restraint systems for all children on all commercial airline flights; and (b) work with the Federal Aviation Administration to establish criteria for appropriate child restraint systems.

Your Reference Committee heard mixed testimony on Resolution 413. Testimony supported the need to provide protections for children from turbulence and sudden changes in altitude. Testimony also reported on challenges families face when attempting to restrain children while traveling, including, but not limited to, breastfeeding and international restrictions prohibiting car seat use while in airplanes. Your Reference Committee offers amended language that reconciles these concerns. Therefore, your Reference Committee recommends that Policy H-45.989 be adopted as amended.

(8) RESOLUTION 417 - AUTO HEAT DEATHS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 417 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association endorse development of a program of concerted efforts support efforts to reduce deaths of children left in unattended vehicles; and be it further,~~

~~RESOLVED, That our AMA urge automobile manufacturers to develop sensors that will alert key holders when unattended persons are in a vehicle.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 417 be adopted as amended.

HOD ACTION: Resolution 417 adopted as amended.

Resolution 417 asks that our AMA (1) endorse development of a program of concerted efforts to reduce deaths of children left in unattended vehicles and (2) urge automobile manufacturers to develop sensors that will alert key holders when unattended persons are in a vehicle.

Your Reference Committee heard testimony in support of this resolution. The author suggested deletion of the second resolve, to which other speakers agreed and your Reference Committee concurred. It was noted that the National Highway Transportation and Safety Administration (NHTSA) launched a campaign in 2014, entitled "Where's Baby? Look Before You Lock!", which addresses this very topic. Your Reference Committee suggested amending the first resolve such that it would support a variety of ongoing efforts, including campaigns. Therefore your Reference Committee recommends that Resolution 417 be adopted as amended.

(9) RESOLUTION 414 - HEADPHONE PUBLIC AWARENESS CAMPAIGN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-15.952 be amended by addition and deletion to read as follows:

~~H-15.952 Ban the Use The Dangers of Distraction While Operating of Hand-Held Devices While Driving~~

1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery. 2. Our American Medical Association will endorse legislation that would ban the use of hand-held devices while driving.

3. Our AMA: (A) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (B) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it. 4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states. 5. Our AMA: (A) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (B) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking. (Res. 217, I-08; Appended: Res. 905, I-09; Appended: BOT Rep. 10, A-13; Appended: Res. 416, A-13)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-15.952 be adopted in lieu of Resolution 414.

HOD ACTION: HOD Policy H-15.952 adopted as amended in lieu of Resolution 414.

Resolution 414 asks (1) that our AMA develop a national public awareness campaign to educate the public about the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding, and walking, (2) that our AMA's public awareness campaign about the dangers of using earbuds or headphones should highlight that the use of earbuds or headphones while driving is illegal and dangerous, and (3) that our AMA support or cause to be introduced legislation requiring warning labels to be printed on packaging of smart phones and similar devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

Your Reference Committee heard mixed testimony on this issue. Testimony noted the importance of education and awareness regarding distraction while operating held-held devices, particularly those with headphones. Concern was raised regarding the potential fiscal note of a national public awareness campaign. Also, testimony questioned if this issue was outside of the purview of the AMA. Your Reference Committee was informed that the National Highway Transportation and Safety Administration (NHTSA) launched a national campaign (Distraction.Gov) on this very issue, which addresses the concern raised in the second resolve. Your Board of Trustees issued a report on Distracted Walking, adopted in 2013, which recognizes distracted walking as a preventable hazard, encourages awareness of the hazard by physicians and the public, and encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it. Given that the subject matter in this resolution is closely related to the AMA Policy adopted as a result of the Board Report, your Reference Committee thought it best to coalesce these issues. Therefore, your Reference Committee recommends that Policy H-15.952 be amended to include the language from this resolution, and that the title of the policy be amended to reflect that change.

(10) RESOLUTION 402 - LABELING AND RECOMMENDED PROTECTION FOR SUNGLASSES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 402 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA recommend that manufacturers clearly label all sunglasses with the percentage of UVA and UVB radiation blocked reflected so that consumers know the extent to which the glasses protect against both types of UV radiation.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 402 be adopted as amended.

HOD ACTION: Resolution 402 adopted as amended.

Resolution 402 asks that our AMA (1) recognize, based on current evidence, that sunglasses that protect against 100% of both UVA and UVB radiation are currently the safest choice for consumers (2) recommend that manufacturers clearly label all sunglasses with the percentage of UVA and UVB radiation reflected so that consumers know the extent to which the glasses protect against both types of UV radiation.

Your Reference Committee heard testimony that was largely in support of the principles of Resolution 402. Testimony stated that there should be transparency in labeling so that consumers are aware of available protections against UVA and UVB radiation. Additionally, testimony presented recommended changing the original language of “reflected” to “absorbed.” Your Reference Committee reviewed existing standards for sunglass labeling and reached consensus on amending the original language of “reflected” to “blocked” based on current guidelines from the American Academy of Ophthalmology and the American Optometric Association.

(11) RESOLUTION 408 - SUSTAINABLE COMMUNITY-BASED FALLS PREVENTION PROGRAMS TO OPTIMIZE FUNCTIONAL OUTCOMES IN ELDERLY POPULATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Resolution 408 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association work with relevant organizations to ~~encourage research into~~ support community-based falls prevention programs.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 408 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 408 be changed to read as follows:

COMMUNITY-BASED FALLS PREVENTION PROGRAMS

HOD ACTION: Resolution 408 adopted as amended with a change in title.

Resolution 408 asks that our AMA work with relevant organizations to encourage research into community-based falls prevention programs.

Your Reference Committee heard testimony supporting efforts that prevent community-based falls. Testimony also expressed concerns about the need for more evidence regarding efficacy of community-based falls prevention

programs. It was noted that the American Occupational Therapy Association and other related organizations provide resources to educate the public on strategies to reduce fall risk. Your Reference Committee recommends adoption of resolution 408 with a title change to support prevention of community-based falls by working with relevant organizations and acknowledging that organizations including the Centers for Disease Control and Prevention (CDC) and the National Council on Aging support and disseminate information, research and evidence-based interventions to prevent falls.

(12) RESOLUTION 409 - ADDRESSING IMMIGRANT HEALTH DISPARITIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 409 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association urge federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; and be it further

RESOLVED, That our AMA, advocate for against and publicly correct medically inaccurate information accusations that contribute to reduce anxiety, fear, and marginalization of specific populations; and be it further

RESOLVED, That our AMA advocate for policies to make available and effectively deploy resources needed to narrow eliminate health disparities borne by affecting immigrants, refugees or asylees.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 409 be adopted as amended.

HOD ACTION: Resolution 409 adopted as amended.

Resolution 409 asks that our AMA (1) urge federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology, (2) advocate against and publicly correct medically inaccurate accusations that contribute to anxiety, fear, and marginalization of specific populations, and (3) advocate for policies to make available and effectively deploy resources needed to narrow health disparities borne by immigrants, refugees or asylees.

Your Reference Committee heard testimony in support of Resolution 409. During the testimony it was requested that clarification be provided on medically inaccurate statements and concerns were presented that the proposed resolution represented a value judgment, which was not consistent with the intent of the resolution. Your Reference Committee agreed to amend the resolution to support advocating for “medically accurate information” and “to eliminate” health disparities affecting immigrants.” Your Reference Committee recommends that Resolution 409 be adopted as amended.

(13) RESOLUTION 401 - ERADICATING HOMELESSNESS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support improving the health outcomes and decreasing the health care costs of treating the chronically

homeless through clinically proven, high quality, and cost effective approaches such as through Housing First approaches, which recognize the positive impact of stable and affordable housing coupled with social services

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 401 be adopted as amended.

HOD ACTION: Resolution 401 adopted as amended.

Resolution 401 asks that our AMA (1) support improving the health outcomes and decreasing health care costs of treating the chronically homeless through Housing First approaches (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness.

Your Reference Committee heard testimony in strong support of Resolution 401, particularly with regards to the direct linkage between homelessness and poor health outcomes as a social determinant of health. Testimony was heard that individuals who are homeless experience challenges in properly storing their medications and managing their health care. Testimony was also heard that individuals who are homeless are more susceptible to being victims of violence. Additional testimony was heard in support of Housing First, an initiative developed by the National Alliance to End Homelessness which centers on providing homeless people with housing quickly and then providing services as needed. Testimony provided also raised concerns about the Housing First program's effectiveness among a subset of the homeless who are dually-diagnosed with mental health or substance abuse issues. Because many factors influence homelessness, your Reference Committee recommends extending support to many approaches to combat homelessness, including but not limited to Housing First.

(14) RESOLUTION 416 - FOOD ALLERGY NOTIFICATION BY RESTAURANTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 416 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association pursue introduction of federal legislation modeled after the Massachusetts Food Allergy Awareness Act, requiring restaurants and food establishments to:

- (1) include a notice in menus reminding customers to let the staff know of any food allergies;
- (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and
- (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 416 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 416 be changed to read as follows:

PREVENTING ALLERGIC REACTIONS IN FOOD SERVICE ESTABLISHMENTS

HOD ACTION: Resolution 416 adopted as amended with a change in title.

Resolution 416 asks that our AMA pursue introduction of federal legislation modeled after the Massachusetts Food Allergy Awareness Act, to make restaurants and food service establishments safer for patrons with food allergies.

Your Reference Committee heard overwhelming favorable support for increasing alerts prompting consumers to notify food establishments of food allergens and for education of food establishment staff. Your Reference Committee recognizes that food sensitivities are subjective and thus recommends that Resolution 416 only include food allergies. Testimony provided for modeling of the Massachusetts Food Allergy Awareness Act was acknowledged. However, your Reference Committee recommends the provisions be included but Resolution 416 not be limited to the Massachusetts Act.

(15) RESOLUTION 420 - BANNING THE USE OF ARTIFICIAL TRANS FATS IN THE UNITED STATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-150.941 be amended by deletion to read as follows:

BANNING THE USE OF ARTIFICIAL TRANS FATS IN RESTAURANTS AND BAKERIES IN THE UNITED STATES

Our AMA supports state and federal legislation that bans the use of artificial trans fats ~~in restaurants and bakeries~~ in the United States.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-150.941 be adopted in lieu of Resolution 420.

HOD ACTION: HOD Policy H-150.941 adopted as amended in lieu of Resolution 420.

Resolution 420 asks that our AMA support a total ban on using artificial trans fats in food products.

Your Reference Committee heard favorable testimony in support of a ban on artificial trans fats in the United States, citing various health effects. Testimony included the acknowledgement of the FDA's pending ban of artificial trans fats, to be announced on June 15, 2015. Your Reference Committee thanks the FDA for its testimony at the hearing. Your Reference Committee recommends amending existing policy with a title change to reflect a ban on artificial trans fats in the U.S. that is not limited to restaurants and bakeries, as currently stated in Policy H-150.941.

(16) RESOLUTION 412 - REGULATION OF ELECTRONIC CIGARETTES
RESOLUTION 419 – TAXATION OF TOBACCO PRODUCTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-495.987 be amended by addition and deletion to read as follows:

H-495.987 Taxation of All Tobacco Taxes Products and Electronic Nicotine Delivery Systems (ENDS)

(1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to ~~pass~~ increased federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to

discourage ~~tobacco~~ use. (2) An increase in federal, state, and local excise taxes for ~~tobacco~~ such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. (3) Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating ~~the tobacco~~ such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education. (CSA Rep. 3, A-04; Modified: BOT Rep. 8, A-05; Reaffirmed: BOT Rep. 8, A-08)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-495.972 be amended by addition to read as follows: H-495.972 Electronic Cigarettes, Vaping, and Health: 2014 Update 1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about “vaping” or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes. (CSAPH Rep. 2, I-14)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that amended Policies H-495.987 and H-495.972 be adopted in lieu of Resolutions 412 and 419.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Policy H-495.973 be reaffirmed.

HOD ACTION: HOD Policies H-495.987 and H-495.972 adopted as amended in lieu of Resolutions 412 and 419 and Policy H-495.973 reaffirmed.

Resolution 412 asks that our AMA (1) support a ban on the advertising of electronic cigarettes and other nicotine delivery devices not approved by the Food and Drug Administration as smoking cessation aids, (2) hold a position that e-cigarettes should be regulated, at the federal, state and local level, consistent with tobacco products until such a time that they are approved by the FDA as smoking cessation aids, (3) support education of the public on the known and potential health impacts of electronic cigarettes and other nicotine delivery devices, and (4) support the taxation of electronic cigarettes and other nicotine delivery devices, not approved by the FDA as smoking cessation aids, to generate funds which could be used for, but not be limited to 1) support for research into their efficacy as smoking cessation aids and their health impacts and 2) education on their known and potential health impacts.

Resolution 419 asks that our AMA support (1) legislation that taxes tobacco products and (2) legislation that taxes electronic nicotine delivery systems (ENDS) similarly to other tobacco products.

Your Reference Committee heard significant testimony in support of FDA regulation of electronic nicotine delivery systems (ENDS), including e-cigarettes; taxation of ENDS; the need for increased education about the subject; and opposition to the advertising of ENDS as a smoking cessation aid. Testimony expressed concern for possible confusion among physicians and the public regarding the appropriate terminology for these products. Related issues were raised in testimony, such as “vaping”, non-nicotine electronic devices, and the socialization of youth as related to these products; however, your Reference Committee felt it germane to focus on ENDS in this resolution. It was noted that your Council on Science and Public Health recently reviewed this topic in their report “Electronic Cigarettes, Vaping, and Health: 2014 Update” (I-14). Your Reference Committee concurs with testimony about the potential dangers of ENDS, particularly the impact on neonates, newborns, and adolescents. The FDA provided testimony indicating that they are working diligently to review the abundance of comments on the proposed rule regarding regulation of ENDS and e-cigarettes. Our AMA submitted comments to the FDA in August 2014 in support of this pending rule. In deliberation, your Reference Committee gave careful consideration to current AMA policy regarding tobacco products and ENDS so as to identify any possible duplication and take the opportunity to strengthen current policy.

Regarding Resolution 412, AMA Policy H-495.973 addresses opposition to promoting ENDS as a cessation aid as well as support of FDA regulation, thereby addressing the first and second resolvs. Policy H-495.972 addresses the importance of educating physicians and could be expanded to include education of the public, thereby addressing the third resolve. Your Reference Committee noted that Policy H-495.987, which addresses taxation of tobacco products, could be amended to include ENDS, thereby addressing the fourth resolve. Consideration was given to use of the phrase “other nicotine delivery devices” as written in the third and fourth resolvs, as that could include regulated products such as the nicotine patch and gum; this distinction makes it different from ENDS. Therefore, your Reference Committee recommends that Policies H-495.987 and H-495.972 be amended and that Policy H-495.973 and be reaffirmed in lieu of this resolution.

Regarding Resolution 419, the first resolve supports tax on tobacco products and the second resolve supports tax on ENDS. Much like the fourth resolve of Resolution 412, your Reference Committee concurs that Policy H-495.987 “Tobacco Tax” could be amended to include ENDS, noting that the title would need to be changed to reflect the amendment.

Policies recommended for reaffirmation:

H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products
 Our AMA: (1) supports the U.S. Food and Drug Administration’s (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth.

(17) **RESOLUTION 421 - RAISING THE MINIMUM LEGAL AGE TO PURCHASE TOBACCO PRODUCTS TO 21**
RESOLUTION 424 – CHILD-PROOF PACKAGES FOR E-CIGARETTE LIQUID REFILLS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-495.986 be amended by addition and deletion to read as follows:

H.495.986 Tobacco Product Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes

Our AMA (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-495.986 be adopted in lieu of Resolutions 421 and 424.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Policies H-495.973 and H-495.972 be reaffirmed.

Resolution 421 asks that our AMA amend subsection (1) of policy H-495.986, Tobacco Product Sales and Distribution, by addition to read as follows:

Our AMA (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors.

Resolution 424 asks that our AMA (1) support regulations and/or legislation to have the Food and Drug Administration (FDA) require that liquid nicotine be only available in child-resistant packages, (2) work toward achieving that the sale of nicotine come with appropriate warnings of the dangers of nicotine and instructions on its safe storage, and (3) work toward a prohibition in the United States on the sale and distribution of liquid nicotine to anyone under the age of 21.

Your Reference Committee heard unanimous testimony in support of a minimum age of 21 years for purchasing all tobacco products, to include ENDS and e-cigarettes. The FDA provided testimony which noted a recent IOM report which concludes that a raise in the minimum age to 21 would significantly reduce youth smoking. The FDA also noted that it cannot raise the minimum age, but that Congress and states can do so. Your Council on Science And Public Health recently reviewed this topic in their report “Electronic Cigarettes, Vaping, and Health: 2014 Update” (I-14). As noted in earlier testimony, your Reference Committee shares the concerns of the speakers regarding susceptibility of youths. Your Reference Committee gave careful consideration to current AMA policy regarding tobacco products and ENDS so as to identify any possible duplication and strengthen current policy.

Regarding Resolution 421, Your Reference Committee concurred with the amendment provided by the author, noting that it would strengthen current AMA policy. Given this amendment, the title of the current policy should reflect the change.

Regarding Resolution 424, Policy H-495.973 addresses child-proof packaging, thereby addressing the first resolve and second resolves. Policies H-490.909 and H-495.972 also address the second resolve. The fourth resolve, much like Resolution 421, asks for support of the minimum age of 21. As such, Policy H-495.986 could be amended as suggested in Resolution 421. Therefore, your Reference Committee recommends that Policy H-495.986 be amended as described and that Policies H-495.973, H-495.972, and H-490.909 be reaffirmed in lieu of Resolutions 421 and 424.

HOD ACTION: HOD Policy H-495.986 adopted as amended in lieu of Resolutions 421 and 424 and Policies H-495.973 and H-495.972 reaffirmed.

Policies recommended for reaffirmation:

H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products
 Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth.

H-490.909 Use of Electronic Cigarettes in Smoking Cessation Programs

Our AMA urges that: (1) e-cigarettes be classified as (nicotine) drug delivery devices and should be subject to FDA regulation with appropriate standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use, including age of the user; (2) state legislatures prohibit the sales of e-cigarettes and all other nicotine devices that are not FDA-approved; and (3) as currently marketed, e-cigarettes be included in smokefree laws but separately defined from tobacco products.

H-495.972 Electronic Cigarettes, Vaping, and Health: 2014 Update

1. Our AMA urges physicians to: (a) educate themselves about e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes.

(18) **RESOLUTION 404 - ALTERING SCHOOL DAYS TO ALLEVIATE ADOLESCENT SLEEP DEPRIVATION**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 404 be referred.

HOD ACTION: Resolution 404 referred.

Resolution 404 asks that our AMA support appropriate entities in establishing clear evidence-based recommendations from existing research on adolescent sleep needs and school start times and that our AMA support legislation congruent with those guidelines.

Your Reference Committee heard mixed testimony on Resolution 404. Testimony in support of the resolution indicated that school days have been altered in the Twin Cities, Minnesota with minimal problems and that there has been a decrease in auto accidents related to "drowsy-driving." Testimony also presented concerns about potential increased costs to schools and contract negotiations with unions if the school day is altered. Your Reference Committee expressed additional concerns regarding unintended consequences related to the altering school days, such as the impact on youth employment and extra-curricular activities. Currently, AMA Policy identifies insufficient sleep and sleepiness in adolescents as a public health issue and the American Academy Pediatrics policy

urges high schools and middle schools to aim for start times that allow students the opportunity to achieve optimal levels of sleep (8.5–9.5 hours). For these reasons and based on the complexity of the issue, your Reference Committee believes this issue warrants further study and recommends referral.

(19) RESOLUTION 425 - BAN ON POWDERED ALCOHOL DISTRIBUTION AND SALE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 425 be referred.

HOD ACTION: Resolution 425 referred.

Resolution 425 asks that our AMA (1) adopt policy urging the ban of the distribution and sale of powdered alcohol and (2) lobby Congress and the Administration to ban by law or regulation the distribution and sale of powdered alcohol in the U.S.

Your Reference Committee heard significant testimony in support of Resolution 425, citing concerns regarding the potential for misuse particularly among youths. Some testimony questioned if powdered alcohol should be regulated the same as liquid alcohol or if it should be prohibited all together. Noting that the sale and distribution of powdered alcohol was recently approved by the US Alcohol and Tobacco Tax and Trade Bureau, action on this item is pertinent. However, given the many unknowns about this product as well as the questions noted in testimony, your Reference Committee recommends referral so that the AMA can be better informed on this important public health issue.

REPORT OF REFERENCE COMMITTEE E

(1) BOARD OF TRUSTEES REPORT 14 - RISK EVALUATION AND MITIGATION STRATEGIES FOR METHADONE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 14 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 14 adopted and the remainder of the report filed.

Board of Trustees Report 14 provides a brief historical perspective on the risk evaluation and mitigation strategy (REMS) for extended release and long-acting opioids, and evaluates whether an individual REMS for methadone is advisable. The report recommends that Policy D-120.985, “Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone,” be reaffirmed in lieu of Resolution 512-A-14.

Limited testimony was supportive of the Board’s report, noting that methadone is already part of the extended release-long acting REMS, and that manufacturer(s) must bear the costs and responsibilities for developing REMS. Since only two generic manufacturers of methadone exist, both of whom make little profit on the drug, the cost to them of completing a REMS may lead them to stop manufacturing methadone altogether. Your Reference Committee agrees with the Board’s recommendation and believes it should be adopted.

(2) RESOLUTION 513 - INCREASING AWARENESS OF NOOTROPIC USE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 513 be adopted.

HOD ACTION: Resolution 513 adopted.

Resolution 513 asks that our American Medical Association (1) recognize that nootropic use may be a potential health problem; and (2) research the demand, use, and adverse effects of nootropics used individually and in combination.

Testimony described the increasing use of nootropics, i.e., medications or supplements intended to improve cognitive performance, among college students, medical students, and those wanting to maximize their speed and efficiency in completing study assignments, exams, or work responsibilities. Testimony noted that nootropic use may be harmful, but evidence on their effects in people without cognitive deficits is lacking and testing for these effects is challenging. Testimony was supportive of encouraging improved research efforts to better characterize the effects of nootropics in people without cognitive deficits, and the Council on Science and Public Health offered to conduct such a study. Your Reference Committee concurs and recommends adoption.

(3) RESOLUTION 514 - FUNDING THE BRAIN RESEARCH THROUGH ADVANCING INNOVATIVE NEUROTECHNOLOGIES (BRAIN) INITIATIVE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 514 be adopted.

HOD ACTION: Resolution 514 adopted.

Resolution 514 asks that American Medical Association Policy H-460.904 be amended by addition as follows:

H-460.904 The Next Transformative Project: In Support of the BRAIN Initiative

Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; ~~and~~ (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative and thus provides for research and innovation in technologies that will advance knowledge of neurologic function and disease.

Limited but supportive testimony was offered for this resolution, citing the extreme importance of continuing the research advances that have begun through the BRAIN Initiative. Testimony requested that funding for the SmartTOTS initiative should be included in this resolution, but your Reference Committee believes that this initiative is out of scope for Resolution 514. It believes that the AMA should be a strong advocate for research funding and recommends adoption of the resolution.

(4) RESOLUTION 515 - OPPOSE EPA SCIENTIFIC ADVISORY BOARD REFORM ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 515 be adopted.

HOD ACTION: First Resolve of Resolution 515 adopted.

Resolution 515 asks that our American Medical Association (1) reaffirm our strong support for the value independent scientific advice provided by federal advisory panels; (2) oppose legislation seeking to limit the role of scientists on EPA federal advisory panels and increase the role of industry representatives on such panels; (3) oppose legislation seeking to add additional regulatory steps into the EPA federal advisory committee process; and (4) send a letter to Congress expressing our opposition to legislation that a) reduces the role scientific experts play in the EPA federal advisory committee process, b) adds additional process steps to the advisor panel process and c) seeks to increase industry representation on EPA scientific advisory panels.

Considerable testimony was offered in support of Resolution 515 and the concept that the EPA's Scientific Advisory Board should be comprised of individuals who are the foremost experts on environmental issues, and that burdensome requirements that may not serve to enhance the integrity of the selection process are not advisable. Your Reference Committee believes that the concept of independent scientific advice and expertise on the EPA Scientific Advisory Board is important, and therefore recommends adoption of the first Resolve. However, Your Reference Committee is more comfortable with having our advocacy staff review pending legislation in order to ensure that the specific requests are supportable as drafted in the second, third, and fourth Resolves. See item 21 for disposition of these items.

(5) RESOLUTION 516 - OPPOSE SECRET SCIENCE REFORM ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that first Resolve of Resolution 516 be adopted.

HOD ACTION: First Resolve of Resolution 516 adopted.

Resolution 516 asks that our American Medical Association (1) reaffirm our strong support for the value of peer review system in ensuring openness and fidelity in the scientific process; (2) oppose legislation that seeking to limit the science that EPA can use in rulemaking; and (3) send a letter to Congress express our opposition to legislation seeking to limit the science that EPA can use in rule making.

Our AMA strongly supports the value of the peer review system in ensuring openness and fidelity in the scientific process and therefore your Reference Committee supports adoption of the first Resolve. Mostly supportive testimony noted the importance of the EPA having the leeway to consider high quality scientific evidence even if that evidence is not replicable (as is the case with meta-analyses) or completely transparent (as may be the case if confidential patient information is used in studies). Support also was offered for the concept of having “balanced” information to help frame regulatory decision-making on which to make advisory decision. While the requests the second and third Resolves of Resolution 516 seem supportable as written, your Reference Committee believes that having advocacy staff review pending legislation is preferred in order to ensure that the specific requests in draft legislation are supportable as drafted. See item 22 for disposition of these items.

(6) RESOLUTION 522 - MEDICATION EXPIRATION DATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 522 be adopted.

HOD ACTION: Resolution 522 adopted.

Resolution 522 asks that our American Medical Association amend Policy H-115.983 as follows: H-115.983 Expiration Dates and Beyond-Use Dates of Prescription and Over-the-Counter Drug Products Our AMA: (1) supports the inclusion of expiration dates on the containers/labels of prescription and over-the-counter drug products and recommends that expiration dates be determined by pharmaceutical manufacturers using scientifically based stability testing with subsequent approval by the Food and Drug Administration (FDA); (2) urges the pharmaceutical industry, in collaboration with purchasers, the FDA, and the United States Pharmacopeia (USP), to determine whether lengthening of expiration dates will provide clinical and/or economic benefits or risks for patients and, if this is the case, to conduct longer stability testing on their drug products; (3) urges the FDA to work with the pharmaceutical industry and the USP to develop a schedule for the review and re-evaluation of expiration dates of prescription and over-the-counter drug products; (4) recommends that pharmacists place a beyond-use date on the labeling of all prescription medications dispensed to patients, and that the beyond-use date be based on the recommendations in the most recent edition of the United States Pharmacopeia and National Formulary (~~currently USP 24 NF 19~~ (official January 1, 2000)); and (5)(4) encourages the USP, in collaboration with pharmaceutical manufacturers, pharmacy organizations, and the FDA, to continue to explore the development of appropriate stability tests for the determination of scientifically sound beyond-use dates for repackaged products.

Limited testimony suggested that the AMA encourage periodic reviews of expiration dates and beyond-use dates of prescription and over-the-counter drugs. Your Reference Committee concurs; a need for a mechanism to evaluate over-the-counter expiration dates exists. Your Reference Committee therefore recommends that Resolution 522 be adopted.

(7) COUNCIL ON MEDICAL SERVICE-COUNCIL ON SCIENCE AND PUBLIC HEALTH JOINT REPORT 1 - COVERAGE FOR CHRONIC PAIN MANAGEMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service-Council on Science and Public Health Joint Report 1 be amended by addition on lines 31-33 to read as follows:

1. That our American Medical Association advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service-Council on Science and Public Health Joint Report 1 be amended by addition on line 40 to read as follows:

3. That our AMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service-Council on Science and Public Health Joint Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service-Council on Science and Public Health Joint Report 1 adopted as amended and the remainder of the report filed.

Council on Medical Service-Council on Science and Public Health Joint Report 1 reviews considerations for coverage of chronic pain management. It recommends that our American Medical Association (1) advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that are physician-led and recognize the interdependency of treatment methods in addressing chronic pain; (2) support health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits; and (3) support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services.

Both Councils were congratulated for a concise, well-written report that explored the issues of access to comprehensive, multidisciplinary treatment and insurance coverage for patients suffering from persistent pain. Overall the testimony supported the recommendations of the report, with a suggestion to include mental health professionals in the assessment of co-occurrences of mental disorders and substance use disorders, and the need to address physical, psychological, and medical aspects of the patient's condition. The Council on Science and Public Health concurred with the amendments. Your Reference Committee concurs and recommends adoption as amended.

(8) **RESOLUTION 501 - ADDRESSING DRUG OVERDOSE AND PATIENT COMPLIANCE WITH TARGETED PHARMACEUTICAL PACKAGING EFFORTS**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 501 be amended by addition and deletion on lines 21-23 to read as follows:

RESOLVED, That our American Medical Association support research into, and development of, into novel and affordable pharmaceutical packaging for dispensed medications, as well as abuse deterrent formulations in attempts to increase ease of use, improve patient adherence compliance, and decrease the abuse potential for misuse and abuse of controlled substances.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 501 be adopted as amended.

HOD ACTION: Resolution 501 adopted as amended.

Resolution 501 asks that our American Medical Association support research into novel and affordable pharmaceutical packaging in attempts to increase ease of use, improve patient compliance, and decrease abuse potential.

Limited but supportive testimony was offered for this resolution. Supporters cited examples of next-generation pharmaceutical packaging with microchips incorporated into blister packs to allow for the capture of use-related data. Because the resolution focuses on dispensed medications, your Reference Committee added a qualifier to distinguish the term “pharmaceutical packaging” from the packaging of medications from manufacturers and distribution centers. Your Reference Committee also believes that the term “adherence” is preferred to the term “compliance.” In addition to novel packaging methods to improve adherence and reduce medication misuse, a suggestion was made to expand this resolution to include our AMA supporting the development of abuse deterrent formulations for controlled substances as a key strategy to reduce misuse.

(9) RESOLUTION 502 - RECOGNIZING LONG-ACTING REVERSIBLE CONTRACEPTIVES AS EFFICACIOUS AND ECONOMICAL FORMS OF CONTRACEPTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 502 be amended by addition and deletion on lines 27-32 to read as follows:

~~RESOLVED, That our American Medical Association study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and be it further~~

RESOLVED, That our AMA support the training of all primary care physicians providers and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 502 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 502 be changed.

TRAINING IN PRECONCEPTION COUNSELING AND LONG-ACTING REVERSIBLE CONTRACEPTIVE METHODS

HOD ACTION: Resolution 502 adopted as amended with a title change.

Resolution 502 asks that our American Medical Association (1) study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and (2) support the training of all primary care providers in the area of preconception counseling.

Tremendously supportive testimony was heard for efforts to prevent teen pregnancy and for the use of long-acting reversible contraceptives methods to achieve such prevention and minimize barriers for the use of effective contraception. Current AMA policy supports efforts to prevent unintended pregnancy. Your Reference Committee believes that the study called for in the resolution is not necessary given the well-understood consequences of unintended pregnancy and effective contraceptive methods. It therefore recommends adoption of an amendment deleting the first Resolve and supporting training of primary care physicians and other health professionals in preconception counseling.

(10) RESOLUTION 504 - PHYSICIAN DETERMINATION FOR APPROPRIATE MEDICAL REFILLS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 504.

REFILLS FOR FORMULATIONS SUBJECT TO WASTE DURING SELF-ADMINISTRATION

RESOLVED, That our American Medical Association (AMA) strongly encourage insurance and pharmacy benefit management companies to refrain from denying coverage for liquid, ointments, gels, cream and other formulations that are difficult and/or imprecise to self-administer and therefore may be completely used prior to their refill date; and be it further

RESOLVED, That Policies H-120.943 and H-120.952 be reaffirmed.

HOD ACTION: Original Resolution 504 adopted.

Resolution 504 asks that our American Medical Association study the prevalence of medication dispensing and refill restrictions on ophthalmic and other “difficult to dose” medications and the effect they have on patient care when medically necessary refills are denied or delayed due to the arbitrary determination by non-physicians of what actually constitutes a one or three month supply of ophthalmic and other medications. The results of the study and recommendations to resolve the problem in favor of our patients should generate a report back to the House of Delegates at the 2015 Interim Meeting of the AMA.

Testimony noted that current AMA policy supports establishing a month’s supply as 31 days, and a three month’s supply as 93 days; furthermore, prescription refills should provide the appropriate number of doses for the time period specified by the physicians. This situation might apply, for example, if the physician changes the dosage regimen during a refill period. Testimony also highlighted the fact that many dosage forms (eye drops, liquids, creams, salves, etc) are prone to waste or difficult to administer precisely, particularly by elderly patients. Since many payers do not take this unintentional wastage into account, they will often deny coverage for a refill before the refill date occurs. AMA Policy opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions. Your Reference Committee believes this is an important issue that warrants policy now, rather than waiting for a study or report to establish policy. It therefore recommends adoption of a Substitute Resolution to cover a broader range of applicable clinical situations.

Policy to be reaffirmed:

H-120.943 Adequate Prescription Medication Supply

Our AMA urges health plans to: (1) define a month’s supply as a minimum of 31 days and three month’s supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (2) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician.

H-120.952 Restriction on Prescription Refills

1. Our AMA opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions including, but not limited to: (A) restricting refill hours to less than usual pharmacy hours; (B) restricting refills to limited pharmacies rather than all participating pharmacies; (C) restricting refills for chronic medications to a less than 90-day supply; and (D) restricting the date of refill. 2. Our AMA will encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the need for multiple renewal requests and travel barriers for prescription acquisition.

(11) RESOLUTION 505 - PRESCRIPTION PRODUCT LABELING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-115.994 be amended by addition and deletion to read as follows:

H-115.994 Prescription Product Labeling

The official labeling should not be regarded as a the sole legal standard of acceptable or accepted medical practice nor as a substitute for clinical judgment or experience nor as a limitation on usage of the drug in medical practice. The official labeling statements approved by the FDA establish the parameters governing advertising or promotion of the drug product.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-115.994 be adopted in lieu of the first Resolve of Resolution 505.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 505 be amended by addition and deletion on lines 21-23 to read as follows:

RESOLVED, That our AMA advocate that the FDA work to establish a process whereby the official drug labeling can be updated in a more expeditious fashion when new evidence becomes available affecting the clinical use of prescription medications and that evidence-based standards and or peer reviewed medical literature can improve upon add to legacy information contained in official drug labeling statements to better guide drug administration and usage.; and be it further

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the third Resolve of Resolution 505 be amended by deletion.

RESOLVED, That our AMA work with the National Association of Boards of Pharmacy and other involved federal regulators and stakeholders regarding interpretation and use of drug product labeling statements in the context of medical practice.

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Resolution 505 be adopted as amended.

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that Policy H-120.988 be reaffirmed.

HOD ACTION: Amended Policy H-115.994 adopted as amended, Policy H-120.988 reaffirmed and Resolution 505 adopted as amended:

RESOLVED, That our AMA advocate that the FDA work to establish a process whereby the official drug labeling can be updated in a more expeditious fashion when new evidence becomes available affecting the clinical use of prescription medications and that evidence-based standards or peer-reviewed medical literature can add to legacy information contained in official drug labeling statements to guide drug administration and usage.

Resolution 505 asks that our American Medical Association (1) advocate that the official labeling on drugs should not be regarded as a legal standard of acceptable or accepted medical practice nor as a substitute for clinical judgment or experience nor as a limitation on usage of the drug in medical practice. The official labeling statements approved by the FDA should establish the parameters governing advertising or promotion of the drug product; (2) advocate that evidence-based standards and peer-reviewed medical literature can improve upon legacy information contained in official drug labeling statements to better guide drug administration and usage; and (3) work with the National Association of Boards of Pharmacy and other involved federal regulators and stakeholders regarding interpretation and use of drug product labeling statements in the context of medical practice.

Testimony noted that the official product labeling for FDA-approved medications does constitute a legal standard, however, off-labeled uses are legally permissible and new clinically-relevant information may become available that is not reflected in the product labeling. Accordingly, the product labeling should not be regarded as *the* legal standard. Furthermore, it is generally agreed that the advice contained in prescription drug product labeling lags behind the development of new evidence, and a more expeditious path to updating product labeling is needed. This issue has been of particular concern for physicians who frequently prescribe certain topical treatments for off-label use and experience challenges in obtaining the prescription from the pharmacy for that indication, and in insurance coverage for the product. Finally, your Reference Committee believes that the third Resolve is not a necessary or feasible approach.

Policy recommended for reaffirmation:

H-120.988 Patient Access to Treatments Prescribed by Their Physicians

(1) Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate "off-label" uses of drugs on their formulary. (2) Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. (3) Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. (4) Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use). (5) Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. (6) Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

(12) RESOLUTION 506 - REDUCTION OF CARBON DIOXIDE POLLUTION FROM ENERGY PRODUCTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-135.949 be amended by addition and deletion to read as follows:

H-135.949 Support of Clean Air and Reduction in Power Plant Emissions Act
 Our AMA supports (1) federal legislation and regulations that meaningfully reduces the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development of alternative renewable energy sources.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy D-135.972 be amended by addition and deletion to read as follows:

D-135.972 Support EPA Regulation Reduction of Carbon Dioxide Emissions Pollution

Our AMA will submit comments to (1) inform the President of the United States, the US Administrator of the Environmental Protection Agency (EPA), and Congress during public comment period on the new proposed rule regarding existing that our American Medical Association supports the Administration's efforts to limit carbon dioxide pollution emissions from power plants emissions to underscore the need to keep the standards strong and protective of public health; and (2) working with state medical societies, encourage state governors to support and comply with EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that amended Policies H-135.949 and D-135.972 be adopted in lieu of Resolution 506.

HOD ACTION: Policies H-135.949 and D-135.972 adopted as amended in lieu of Resolution 506.

Resolution 506 asks that our American Medical Association (1) inform the President of the United States, the Director of the Environmental Protection Agency (EPA), and the Congress that we support the Administration's current efforts to limit carbon dioxide pollution through the reduction of the burning of coal in the nation's power generating plants, that we support the efforts to improve the efficiency of power plants, support the substitution of natural gas in lieu of other carbon based fossil fuels, and that our AMA supports the continued development of alternative renewable energy sources such as wind turbine power, solar photoelectric energy production, and other forms of non-polluting, non-carbon based energy generation; and (2) working in conjunction with state medical societies, encourage state governors to support the EPA regulations designed to limit carbon dioxide emissions from coal fired power plants; and encourage the governors' full compliance with the EPA regulations when promulgated.

Mostly supportive testimony was offered for the reduction of carbon dioxide emissions from power plants and the movement toward renewable energy sources. Some testimony cautioned that the reduction in fossil fuel-based energy could result in the loss of jobs and negatively impact the economy. Others noted that there are several renewable energy sources, such as nuclear power, that could result in carbon dioxide emissions reduction. Your Reference Committee supports the importance of carbon dioxide emissions reduction and alternative renewable energy sources, but recommends amending H-135.949, which already addresses the topic of carbon dioxide emissions. Your Reference Committee also recommends amending D-135.972 to maintain the statement of support to the President, Congress, and the EPA, and the request for all states to support and comply with EPA regulations.

(13) RESOLUTION 507 - NEXT-GENERATION INFECTIOUS DISEASES
DIAGNOSTICS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 507 be amended by addition and deletion on page 2, lines 1-6 to read as follows:

RESOLVED, That our American Medical Association support strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for appropriate agencies the National Institute of Allergy and Infectious Diseases (NIAID), Biomedical Advanced Research and Development Authority (BARDA), The Centers for Disease Control and Prevention (CDC), and establishment of a permanent federal tax credit to cover clinical testing expenses; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 507 be amended by addition and deletion on page 2, lines 18-19 to read as follows:

RESOLVED, That our AMA support efforts to overcome improved reimbursement barriers to ensure coverage of for the cost of emerging diagnostics.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 507 be adopted as amended.

HOD ACTION: Resolution 507 adopted as amended.

Resolution 507 asks that our American Medical Association (1) support strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for the National Institute of Allergy and Infectious Diseases (NIAID), Biomedical Advanced Research and Development Authority (BARDA), The Centers for Disease Control and Prevention (CDC), and establishment of a permanent federal tax credit to cover clinical testing expenses; (2) support the reduction of regulatory barriers to allow for safe and effective emerging rapid diagnostic tests, particularly those that address unmet medical needs, to more rapidly reach laboratories for use in patient care; (3) support improving the clinical integration of new diagnostic technologies into patient care through outcomes research that demonstrates the impact of diagnostics on patient care and outcomes, educational programs and clinical practice guidelines for health care providers on the appropriate use of diagnostics, and integration of diagnostic tests results into electronic medical records; and (4) support improved reimbursement for the cost of emerging diagnostics.

Supportive testimony detailed the pressing need for the development of new and better infectious disease diagnostic tools, both to assist in the targeted and judicious use of antibiotics and to respond rapidly and appropriately to infectious disease outbreaks. The Infectious Diseases Society of America (IDSA) has recently published a policy paper reviewing the actions needed to support the development of improved ID diagnostics, and stated that this resolution is in line with those proposed actions. IDSA also suggested an amendment to the fourth Resolve regarding overcoming reimbursement barriers. Your Reference Committee believes the resolution should be adopted with the IDSA's amendment, and offers amendments to the first Resolve to avoid specifying which agencies should receive increased funding.

(14) RESOLUTION 511 - HEPATITIS C TREATMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-440.845 be amended by addition and deletion to read as follows:

H-440.845 ~~Increased~~ Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with ~~recent~~ Centers for Disease Control and Prevention (CDC) recommendations; ~~and~~ (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (5) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-440.845 be adopted in lieu of Resolution 511.

HOD ACTION: Policy H-440.845 adopted as amended in lieu of Resolution 511.

Resolution 511 asks that our American Medical Association (1) support Hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward patients who would benefit the most, and toward maximum public health benefit; (2) support adequate funding by governments, insurance companies and other third party payers, including negotiation for more reasonable pricing of HCV antivirals, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (3) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines.

Mixed testimony was offered for Resolution 511. Testimony in favor of adopting the resolution addressed challenges faced by patients and providers in correctional facilities. In one state 20-40% of incarcerated individuals are infected with Hepatitis C. Others noted the constitutional right to fair treatment of incarcerated individuals and the potential public health risk of infected individuals re-entering society while not having the opportunity to seek treatment. Some testimony expressed concerns of resources and costs associated with providing Hepatitis C treatment. Your Reference Committee recommends amending current policy on Hepatitis C with key points from Resolution 511.

(15) RESOLUTION 517 - RECREATIONAL USE AND ABUSE OF PRESCRIPTION DRUGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 517.

ADDRESSING RECREATIONAL MISUSE AND DIVERSION OF CONTROLLED SUBSTANCES

RESOLVED, That our American Medical Association, in conjunction with other Federation members, ~~and~~ key public and private stakeholders, ~~and~~ pharmaceutical manufacturers, pursue and intensify collaborative efforts involving a public health approach in order to: 1) reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications; 2) increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and 3) reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

HOD ACTION: Substitute Resolution 517 adopted as amended.

Resolution 517 asks that, in order to prevent abuse and diversion of prescription medications including controlled substances, opioids and other potentially addictive medication, our American Medical Association urge pharmaceutical manufacturers to engage in public awareness campaigns regarding safe use of medication, including dosage, storage, disposal and security, and the illegality of diversion.

Limited testimony noted that it was incumbent upon our AMA to continue to address these issues, and further intensify collaborative efforts in order to promote solutions to what are difficult and complex public health issues facing the American public, patients, and their families, and the healthcare professionals who are entrusted with their treatment. Your Reference Committee therefore recommends a substitute resolution supporting this concept.

(16) RESOLUTION 508 - DISCLOSURE OF ENVIRONMENTAL CHANGES ASSOCIATED WITH HYDRAULIC FRACTURING
 RESOLUTION 510 - NATURAL GAS FRACKING: MONITORING TO PROTECT HUMAN HEALTH

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 508 in lieu of Resolution 510.

CHEMICALS USED DURING THE HYDRAULIC FRACTURING (FRACKING) PROCESS

RESOLVED, That our American Medical Association support the full disclosure of chemicals placed into the natural environment during the petroleum, oil and natural gas exploration and extraction process; and be it further

RESOLVED, That our AMA support the requirement that government agencies record and monitor the chemicals placed into the natural environment for petroleum oil and natural gas extraction and the chemicals found in flowback fluids, to monitor for human exposures in well water and surface water, and to share this information with physicians and the public.

HOD ACTION: Substitute Resolution 508 adopted in lieu of Resolution 510.

Resolution 508 asks that our American Medical Association (1) endorse legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil and natural gas exploration & extraction; and (2) endorse legislation and regulations that require government agencies to record and monitor the chemicals placed into the natural environment for petroleum oil and natural gas extraction and the chemicals found in flowback fluids, to monitor for human exposures in well water and surface water, and to share this information with physicians and the public.

Resolution 510 asks that our American Medical Association (1) support legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil and natural gas exploration &

extraction; and (2) support legislation and regulations that require government agencies to record and monitor the chemicals placed into the natural environment for petroleum oil and natural gas extraction, to monitor for human exposures in well water and surface water, and to share this information with physicians and the public.

Overall supportive testimony encouraged the full disclosure of chemicals being placed during the fracking process. Limited testimony encouraged our AMA to be consistent in the energy policies that it supports. Others noted that this resolution is not an attempt to oppose fracking altogether, but merely an effort to increase transparency and permit further study of the potential public health effects. Your Reference Committee therefore recommends adopting a substitute resolution that echoes the key points in Resolutions 508 and 510.

(17) RESOLUTION 519 - PROTECTING PUBLIC HEALTH FROM NATURAL GAS INFRASTRUCTURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 519 be amended by deletion on page 2, line 21 to read as follows:

RESOLVED, That our American Medical Association recognize the potential impact on human health ~~and the environment~~ associated with natural gas infrastructure; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 519 be amended by addition and deletion on page 2, lines 24-25 to read as follows:

RESOLVED, That our AMA support legislation that would require a comprehensive Health Impact Assessment seek government assessment at all levels regarding the health ~~and environmental~~ risks ~~which that may be are~~ associated with natural gas pipelines.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 519 be adopted as amended.

HOD ACTION: Resolution 519 adopted as amended.

Resolution 519 asks that our American Medical Association (1) recognize the potential impact on human health and the environment associated with natural gas infrastructure; and (2) seek government assessment at all levels regarding the health and environmental risks which are associated with natural gas pipelines.

Limited but supportive testimony pointed out the vast network of natural gas pipelines in this country, and that the majority of the pipelines are aging and in need of significant repairs. Oversight of the network is inconsistent, resulting in differences in the integrity of the infrastructure; accidents resulting in injury and death have occurred. The sponsor offered an amendment to the second Resolve to focus on assessing health risks. An assessment is needed to determine how improvements to the infrastructure could be encouraged and enforced. Your Reference Committee recommends a similar change to the first Resolve to make the requests parallel.

(18) RESOLUTION 523 - EVALUATION OF CANADIAN UNDERGROUND NUCLEAR WASTE REPOSITORY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 523 be amended by addition and deletion on page 2, lines 2-4 to read as follows:

RESOLVED, That our American Medical Association, along with state and county medical societies, urge lobby Congress, the President, and the Secretary of State to invoke the participation of the International Joint Commission to evaluate the proposed underground nuclear waste repository in Ontario, Canada, and similar facilities; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 523 be amended by deletion.

RESOLVED. ~~That our AMA urge the organized medicine entities of the Great Lakes states and Canadian provinces to adopt resolutions seeking regulations to protect the Great Lakes region from radioactive waste and to petition their respective state and federal governments to engage the International Joint Commission to evaluate the proposed underground nuclear waste repository in Ontario, Canada, and similar facilities.~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 523 be adopted as amended.

HOD ACTION: Resolution 523 adopted as amended.

Resolution 523 asks that (1) our American Medical Association, along with state and county medical societies, lobby Congress, the President, and the Secretary of State to invoke the participation of the International Joint Commission to evaluate the proposed underground nuclear waste repository in Ontario, Canada, and similar facilities; and (2) urge the organized medicine entities of the Great Lakes states and Canadian provinces to adopt resolutions seeking regulations to protect the Great Lakes region from radioactive waste and to petition their respective state and federal governments to engage the International Joint Commission to evaluate the proposed underground nuclear waste repository in Ontario, Canada, and similar facilities.

Supportive testimony was offered by the sponsor of the resolution. Your Reference Committee believes that the requests in the first Resolve are the most urgent and effective approaches to ensure analysis and action by entities with vested authorities, and therefore recommends adoption of the first Resolve with a minor amendment, and deletion of the second Resolve.

(19) **RESOLUTION 524 - NUCLEAR WAR**
RESOLUTION 525 - MEDICAL CONSEQUENCES OF NUCLEAR WAR
AND THE NEED TO ABOLISH NUCLEAR WEAPONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that adoption of Substitute Resolution 524 in lieu of Resolution 525.

MEDICAL CONSEQUENCES OF NUCLEAR WAR

RESOLVED, That our American Medical Association (AMA) urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons; and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war; and be it further

RESOLVED, That Policies H-520.988, H-520.994, H-520.995, H-520.996, H-520.999 be reaffirmed.

HOD ACTION: Substitute Resolution 524 adopted in lieu of Resolution 525, and Policies H-520.988, H-520.994, H-520.995, H-520.996 and H-520.999 reaffirmed.

Resolution 524 asks that our American Medical Association (1) urge the US and all national governments to continue to work to ban and eliminate nuclear weapons; (2) through its appropriate Councils, develop a comprehensive educational program on the public health dangers of limited as well as a major nuclear war; and (3) ask the US government to take nuclear weapons off hair trigger alert thereby reducing the likelihood of an accidental, mistaken or unauthorized launch of such a weapon.

Resolution 525 asks that our American Medical Association (1) condemn the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons; request all governments to refrain from the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons and to work in good faith towards the elimination of nuclear weapons; advise the government of the United States, and all national governments, that even a limited nuclear war would have catastrophic effects on the world's food supply and would put a significant proportion of the world's population at risk from a nuclear famine; urge education of the general public that the threat of a limited nuclear war is an overwhelming threat to public health; and urge the government of the United States, and all national governments, to continue to work to ban and eliminate nuclear weapons; and (2) study and report back on the issue of the public health dangers of limited as well as major nuclear war.

Mixed testimony was offered on Resolutions 524 and 525. The sponsors of both resolutions noted that public awareness on the impact of nuclear war has waned since the Cold War Era. While all agree that the public health consequences of limited and major nuclear war are devastating, there were disagreements about the need for the AMA to take a lead role in educating the public and developing a report on the topic. Your Reference Committee believes that a declarative statement about working to ban and eliminate nuclear weapons is warranted, as well as collaborative efforts to raise awareness and educate the public about the health consequences of nuclear war. This could include a media communication by our AMA. It also believes that the extensive AMA policy opposing nuclear war and nuclear weapons sends a strong message about our stance, and recommends reaffirmation of those as well.

Policy recommended for reaffirmation:

H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction

The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction.

H-520.994 Nuclear Test Ban

The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban.

H-520.995 Nuclear Weapons Reduction

The AMA supports continued efforts to publicize its position that there is no adequate medical response to nuclear war.

H-520.996 Arms Reduction

The AMA encourages the President and Congress to continue the process of bilateral and verifiable nuclear arms reduction.

H-520.999 Opposition to Nuclear War

The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust.

(20) RESOLUTION 512 - OFF-LABEL USE OF HORMONE THERAPY

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 work with national health care organizations to advocate on behalf of the public and our patients on the appropriate evaluation and treatment of hormone deficiencies, as well as the side effects from use of hormone therapy without objective evidence to guide treatment, especially when given to promote weight loss or a general feeling of well-being.

Supportive testimony pointed out the increasing use of hormones for non-medical purposes, often prescribed by or obtained from non-physicians. Some of these treatments have not been studied for safety and efficacy, and may put those taking them in danger. Amendments were offered to clarify the intent and language of the resolution. Some caution was expressed for implying that weight loss is a non-medical issue, and that some hormones are indeed used to support weight loss under a physician's care. Additionally, hormones are used off-label for gender affirming therapy. Your Reference Committee believes that this is a complex issue involving many questions, and that the topic would benefit from a study by the appropriate AMA Council. Therefore, it recommends referral.

(21) RESOLUTION 515 - OPPOSE EPA SCIENTIFIC ADVISORY BOARD REFORM ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the second, third, and fourth Resolves of Resolution 515 be referred for decision.

HOD ACTION: Resolves 2, 3, and 4 of Resolution 515 referred for decision.

Resolution 515 asks that our American Medical Association (1) reaffirm our strong support for the value independent scientific advice provided by federal advisory panels; (2) oppose legislation seeking to limit the role of scientists on EPA federal advisory panels and increase the role of industry representatives on such panels; (3) oppose legislation seeking to add additional regulatory steps into the EPA federal advisory committee process; and (4) send a letter to Congress expressing our opposition to legislation that a) reduces the role scientific experts play in the EPA federal advisory committee process, b) adds additional process steps to the advisor panel process and c) seeks to increase industry representation on EPA scientific advisory panels.

Considerable testimony was offered in support of Resolution 515 and the concept that the EPA's Scientific Advisory Board should be comprised of individuals who are the foremost experts on environmental issues, and that burdensome requirements that may not serve to enhance the integrity of the selection process are not advisable. Your Reference Committee believes that the concept of independent scientific advice and expertise on the EPA Scientific Advisory Board is important, and therefore recommends adoption of the first Resolve (see item 4). However, Your Reference Committee is more comfortable with having AMA advocacy staff review pending legislation in order to ensure that the specific requests are supportable as drafted. Therefore, the second, third, and fourth Resolves are recommended for referral for decision.

(22) RESOLUTION 516 - OPPOSE SECRET SCIENCE REFORM ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the second and third Resolves of Resolution 516 be referred for decision.

HOD ACTION: Resolves 2 and 3 of Resolution 516 referred for decision.

Resolution 516 asks that our American Medical Association (1) reaffirm our strong support for the value of peer review system in ensuring openness and fidelity in the scientific process; (2) oppose legislation that seeking to limit the science that EPA can use in rulemaking; and (3) send a letter to Congress express our opposition to legislation seeking to limit the science that EPA can use in rule making.

Our AMA strongly supports the value of the peer review system in ensuring openness and fidelity in the scientific process, and your Reference Committee recommends adoption of the first Resolve to affirm such support (see item 4). Mostly supportive testimony noted the importance of the EPA having the leeway to consider high quality scientific evidence even if that evidence is not replicable (as is the case with meta-analyses) or completely transparent (as may be the case if confidential patient information is used in studies). Support also was offered for the concept of having “balanced” information to help frame regulatory decision-making on which to make advisory decision. While the requests in Resolution 516 seem supportable as written, your Reference Committee believes that having our AMA’s advocacy staff review pending legislation is preferred in order to ensure that the specific requests in draft legislation are supportable as drafted. Therefore, the second and third Resolves are recommended for referral for decision.

(23) RESOLUTION 526 - RECYCLING PHARMACEUTICAL PROFITS TO NIH FUNDING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 526 be referred for decision.

HOD ACTION: Resolves 2 and 3 of Resolution 516 referred for decision.

Resolution 526 asks that our American Medical Association support the concept that pharmaceutical companies that can be shown to have profited from intellectual property publicly funded by the American taxpayer, should provide for a share of that profit from pharmaceuticals whose research can be attributed to the National Institutes of Health (NIH), and that those funds be made available as supplemental appropriations to support and grow biomedical research at NIH.

Testimony emphasized inadequate funding of the National Institutes of Health (NIH), the fact that many pharmaceutical companies have benefitted from tax payer-funded scientific findings, and that some of the profits gained by such companies should be used to help fund the NIH. Testimony also noted that the resolution fails to recognize the complimentary roles of NIH and industry and disregards the critical role that investments by industry play in transforming scientific findings from basic research into research and development pipelines and potential new medicines. Furthermore, in cases where federal research agencies’ or federally funded institutions’ translational research results in patents, they are able to retain ownership and obtain royalties for patented inventions via licensing to the private sector. Some sentiment was expressed for reaffirming current AMA policies related to NIH funding. Given the complex issues involved and whether this is a specific approach that our AMA should endorse, your Reference Committee recommends referral for decision.

(24) RESOLUTION 503 - HEALTH EFFECTS OF REDUCED PASSENGER SPACE FOR LONG DISTANCE AND INTERNATIONAL TRAVEL

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-45.998 and H-45.979 be reaffirmed in lieu of Resolution 503.

HOD ACTION: Policies D-45.998 and H-45.979 reaffirmed in lieu of Resolution 503.

Resolution 503 asks that our American Medical Association (1) express its concerns about passenger health and safety, specifically those issues related to reduced passenger space such as deep vein thrombosis risk, mental anguish and exacerbation of musculoskeletal conditions (e.g. knee and back problems), particularly during long and

overnight flights to the major passenger airlines and the Federal Aviation Administration; and (2) reaffirm its existing policies regarding air passenger safety and also communicate those policies to the airline industry and the FAA.

Limited but supportive testimony was offered for this resolution. Those testifying noted the continued reduction in seating space on airplanes, and the associated dangers of space limitation, such as the risk for venous thromboembolic event (VTE). Your Reference Committee is aware that the Council on Science and Public Health has previously studied the risks of flight-associated DVT, and that current policy urges the Federal Aviation Administration (FAA) and airlines to provide comprehensive educational modalities on VTE prevention. Current policy also addresses travel safety, encouraging the FAA and the airline industry to implement regulations and practices to meet the health needs of airline passengers and crews. Your Reference Committee believes the issue of flight-associated health risks is important, but believes that current policy sufficiently addresses the issues.

Policies recommended for reaffirmation:

D-45.998 Reducing the Risk of Flight-Associated Venous Thrombosis

Our AMA will continue to monitor research on developments concerning the relationship between air travel and venous thromboembolism and respond appropriately when more definitive results become available, and urges the Federal Aviation Administration and individual airlines to provide more comprehensive educational modalities detailing DVT prevention for all long-duration domestic and international airline flights.

H-45.979 Air Travel Safety

Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar.

REPORT OF REFERENCE COMMITTEE F

(1) BOARD OF TRUSTEES REPORT 1 - FUNDING OF AMA REGION AND SECTION DELEGATES / ALTERNATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 1 adopted and the remainder of the Report filed.

Board of Trustees Report 1 comes in response to Resolution 612-A-14, which called upon our AMA to fund transportation and housing for the Annual and Interim meetings for the medical student regional delegates and alternates and the resident physician section delegates and alternates. State and specialty societies, which have section and regional delegates elected from their membership, would continue to provide meals and other miscellaneous reimbursements.

In this report, the Board of Trustees explains that our AMA currently provides substantial support, financial and otherwise, to the medical student and resident/fellow sections. The Board of Trustees concludes that the most appropriate way to gain the benefit of both AMA and Federation support of medical students, residents, and fellows is to maintain the current financial structure for section representation, and it is the Board of Trustees recommendation that Resolution 612-A-14 not be adopted.

At the 2014 Annual Meeting of our AMA House of Delegates, your Reference Committee recommended against adoption of Resolution 612-A-14 based on the testimony that was presented. At that time, your Reference Committee heard how state medical association delegations support the value of regional and section delegates as participants in their delegations because of the bonds that are formed and the ability that exists to prepare future participants in our House of Delegates. Testimony further indicated that since the states are the beneficiaries of the additional regional and section delegates, the states should also bear the expense of these delegates.

Based on average domestic travel expenses for planned future venues, it was estimated that Resolution 612-A-14 would cost our AMA approximately \$355,000 dollars annually in excess of what our AMA currently spends to support section representation.

Ultimately, Resolution 612-A-14 was referred for a report from our Board of Trustees. Based on the information that our Board of Trustees presents in its report and the additional testimony that was presented at this meeting, including the fact that the Medical Student Section and Resident and Fellow Section both testified in favor of maintaining the current financial structure, your Reference Committee stands by its prior position on this matter and therefore favors adoption of our Board of Trustees Report 1.

(2) BOARD OF TRUSTEES REPORT 4 - AMA 2016 DUES

RECOMMENDATION:

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

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

Board of Trustees Report 4 recommends no changes to our AMA membership dues levels for 2016. 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

Beyond the introduction of Board of Trustees Report 4, your Reference Committee received no further testimony. Your Reference Committee wishes to highlight the fact that our AMA's 2016 membership dues levels have not increased in more than 20 years.

(3) **BOARD OF TRUSTEES REPORT 18 - CREATION OF THE AMA SUPER PAC**

RECOMMENDATION:

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

HOD ACTION: Recommendations in Board of Trustees Report 18 referred.

Board of Trustees Report 18 comes in response to Resolution 606-I-14, which called upon our AMA to create and provide significant initial and ongoing funding for an AMA Super PAC to support and/or oppose candidates for federal office based on recommendations from state medical society PACs and support from the American Medical Association Political Action Committee (AMPAC). The resolution further called for the AMA Board of Trustees to identify an organizational structure for an AMA Super PAC Board and to allocate an annual contribution to the Super PAC using AMA reserve funds as a potential source of funding. The AMA Super PAC Board would be expected to develop a plan for soliciting contributions from outside entities eligible to contribute under federal election regulations.

In lieu of Resolution 606-I-14, the Board of Trustees recommends our AMA adopt policy stating that the use of AMA corporate funds, including reserves, is not a fiscally responsible option for funding a Super PAC and should not be pursued. Additionally, the Board of Trustees recommends that our AMA continue to monitor and implement innovative advocacy efforts, which maximize our ability to advance our public policy agenda.

Your Reference Committee received mixed testimony detailing how a Super PAC would strengthen the voice of medicine among elected officials and those individuals seeking such offices. However, our AMA does not have the necessary cash reserves or ability, as a membership organization, to continually amass such funding with which to sustain political activities at this level. To this point, representatives from our American Medical Association Political Action Committee (AMPAC) supported the report and expressed concerns that soliciting external funding could have unintended consequences, including changing our AMA's advocacy agenda. Furthermore, AMPAC has the capacity to initiate independent expenditures.

Your Reference Committee fully supports the recommendations contained in Board of Trustees Report 18, and we strongly encourage members of our AMA House of Delegates to contribute to and support the efforts of AMPAC, which has served for more than 50 years as a key component of our AMA's overall advocacy efforts.

(4) **BOARD OF TRUSTEES REPORT 21 - AMA-PROVIDED INNOVATION GRANTS TO SUPPORT NEW PHYSICIAN MODELS TO IMPROVE QUALITY, EFFICIENCY AND REDUCE COST**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustee Report 21 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 21 adopted and the remainder of the Report filed.

Board of Trustees Report 21 comes in response to Resolution 604-I-14, which called upon our AMA to develop innovation grants to explore new ways to improve quality and efficiency, and reduce cost in all medical practice settings, including independent private practice.

In this report, the Board of Trustees highlights activities in which our AMA is currently involved, including grants and programs that support the exploration of new and innovative ways to help physicians improve quality and efficiency and reduce costs in their practice, regardless of the setting. Given that our AMA is already addressing the intent of Resolution 604-I-14 through current initiatives, the Board of Trustees recommends that the resolution not be adopted.

Your Reference Committee received limited but positive testimony in support of Board of Trustees Report 21. Your Reference Committee believes that the current initiatives outlined in the report address the intent of the resolution and therefore favors adoption of the report in lieu of the resolution.

(5) BOARD OF TRUSTEES REPORT 23 - A VIRTUAL MEDICAL ASSOCIATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 23 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 23 adopted and the remainder of the Report filed.

Board of Trustees Report 23 comes in response to Resolution 601-A-14, which called upon our AMA to provide for virtual attendance of House of Delegates meetings, including the ability to communicate and vote, by 2016 and to provide for virtual reference committees by 2020.

In this report, the Board of Trustees believes that providing full virtual participation in a House of Delegates meeting would be complicated and costly due to logistical and technological complexity, as well as a lack of cultural readiness at this time. Thus, the Board of Trustees recommends that Resolution 601-A-14 not be adopted.

Similar to the testimony presented at the 2014 Interim Meeting, your Reference Committee again received mixed testimony in response to our AMA convening / hosting a virtual House of Delegates meeting. There remains a strong desire for face-to-face interaction, as shown by the fact that prior experiments with virtual reference committees achieved limited success. Additionally, printed handbooks continue to be requested and distributed.

Your Reference Committee encourages our AMA Speakers to continue to pilot the use of technology in the deliberative processes of our House of Delegates.

(6) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Report of the House of Delegates Committee on Compensation of the Officers adopted and the remainder of the Report filed.

The Report of the House of Delegates Committee on Compensation of the Officers recommends there be no changes to the Officers' compensation for the period beginning July 1, 2015 through June 30, 2016.

Your Reference Committee received no testimony in response to the Report of the House of Delegates Committee on Compensation of the Officers and wishes to extend its appreciation to the Committee for its excellent work on behalf of our House of Delegates.

(7) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT
1 - INTERNATIONAL MEDICAL GRADUATES SECTION AND
ORGANIZED MEDICAL STAFF SECTION, FIVE-YEAR REVIEW

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

Council on Long Range Planning and Development Report 1 summarizes the Council's evaluation and makes recommendations to the House of Delegates, through the Board of Trustees, regarding the ongoing delineated section status for the International Medical Graduates Section and the Organized Medical Staff Section. Through this report, the Council on Long Range Planning and Development recommends that our AMA renew delineated section status for the International Medical Graduates Section and the Organized Medical Staff Section through the 2020 Annual Meeting.

On behalf of our House of Delegates, your Reference Committee wishes to extend its appreciation to the Council on Long Range Planning and Development, the International Medical Graduates Section, and the Organized Medical Staff Section for their cooperative and collaborative efforts thereby allowing the Council to present a thorough review of the delineated section status for both Sections. Having received no negative testimony, your Reference Committee supports the Council's conclusion.

(8) RESOLUTION 609 - PHYSICIAN ENTREPRENEUR ACADEMY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 609 be adopted.

HOD ACTION: Resolution 609 adopted.

Resolution 609 calls upon our AMA to study the possibility of developing an entrepreneur and business training academy with online and onsite training and skill development for AMA members.

Your reference committee heard uniformly positive support for this resolution. The practice of medicine is changing rapidly and will benefit from physicians who are well-trained innovators and entrepreneurs, not only in medicine but in business, economics and information technology. Our AMA should explore ways to provide opportunities for physicians to develop these skills.

(9) RESOLUTION 612 - INCREASING COLLABORATION BETWEEN PHYSICIANS AND THE PUBLIC TO ADDRESS PROBLEMS IN HEALTH CARE DELIVERY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 612 be adopted.

HOD ACTION: Resolution 612 adopted.

Resolution 612 calls upon our AMA to consider how to enhance public support of AMA initiatives to improve the delivery of quality medical care. Additionally, the resolution calls upon our AMA to consider creating a Citizens Advisory Group, consisting of patients, lay caregivers, and other non-physician members to assist with understanding the problems confounding the delivery of quality medical care, to educate the public on these matters, and to solicit public involvement in contacting elected officials to advocate for change.

Your Reference Committee received limited testimony on Resolution 612, which included an introduction by the author and a request for referral by our Board of Trustees. Since this resolution calls upon our AMA to consider the outlined initiative, your Reference Committee believes that adopting the resolution would accomplish the same result as a referring it to our Board of Trustees for a report back to our House of Delegates.

(10) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 3 - BEST PRACTICES AND SUCCESSFUL EFFORTS TO INCREASE DIVERSITY, BY AGE, OF AMA DELEGATES AND ALTERNATE DELEGATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Long Range Planning and Development Report 3 be amended by addition and deletion to read as follows:

~~1. That our American Medical Association Young Physician Section engage with young physicians to encourage AMA membership and successful initiatives to promote diversity, by age, among delegations.~~

~~1.2. That part 3 of Policy G-600.035, "The Demographic Characteristics of the House of Delegates," be amended by addition and deletion to read as follows:~~

~~...3. Every five years, a report will be prepared Future reports on the demographic characteristics of the House of Delegates will to identify describe and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations.~~

~~3. That our American Medical Association encourage young physicians to work with their local state associations and medical specialty societies to promote diversity, particularly by age, of state and specialty society delegations.~~

~~2. That our American Medical Association convene a group of relevant stakeholders at an open forum in conjunction with an AMA House of Delegates meeting to describe viable solutions with which to promote diversity, particularly by age, of state and specialty society delegations.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Long Range Planning and Development Report 3 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Long Range Planning and Development Report 3 referred.

Council on Long Range Planning and Development Report 3 examines the current state of age diversity among the AMA House of Delegates, ongoing efforts to promote diversity, and barriers that exist to improving age diversity among state and specialty delegations. The report also makes recommendations for action aimed at improving age diversity.

Your Reference Committee commends the Council on Long Range Planning and Development for their work in developing this detailed report on the diversity of our AMA House of Delegates.

Your Reference Committee noted criticism of the Council for not going far enough with recommending viable solutions for positively affecting the demographics. However, your Reference Committee understands the charge to the Council as outlined in our American Medical Association Policy G-600.035 requires that the Council "...identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations." It is the opinion of your Reference Committee that the Council's responsibility is to report on, and not necessarily create, change in the demographics of our House of Delegates. Therefore, your Reference Committee believes that the Council has met its charge. To address the issues that were raised about the report, your Reference Committee recommends the deletion of recommendations one and three and the insertion of a new resolve calling for an open forum in order to discuss and identify viable solutions that address diversity within our House of Delegates.

(11) **RESOLUTION 607 - PREVENTING VIOLENT ACTS AGAINST HEALTH CARE PROVIDERS**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 607 be amended by addition to read as follows:

RESOLVED, that our American Medical Association work with other organizations, as appropriate, to study mechanisms to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients, and that our AMA widely disseminate the results of this study.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 607 be adopted as amended.

HOD ACTION: Reference Committee recommendation amended.
RESOLVED, that our American Medical Association work with other appropriate organizations, as appropriate, to study mechanisms to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients, and that our AMA widely disseminate the results of this study.

HOD ACTION: Resolution 607 adopted as amended.

Resolution 607 calls upon our AMA to study mechanisms to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients, and that our AMA widely disseminate the results of this study.

Your Reference Committee heard only supportive and passionate testimony in response to Resolution 607. While violence in the workplace is not limited to medical personnel alone, your Reference Committee believes that preventative safety measures may require some unique solutions, such as enhanced criminal penalties, given our obligation and desire to care for all in need of medical care. Our AMA Board of Trustees supports a study of this issue

(12) RESOLUTION 606 - INFORMATIONAL REPORTS SUBMITTED TO THE HOD

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 606 be referred.

HOD ACTION: Resolution 606 referred.

Resolution 606 calls upon our AMA to ensure that informational reports submitted to the House of Delegates are subject to the same actions as non-informational reports and resolutions.

Resolution 606 further calls upon our AMA to label any report or resolution that is not adopted by the House of Delegates as being “Not Accepted by the House of Delegates” to clearly distinguish what is actual AMA policy.

Your reference committee heard testimony largely in support of this resolution. Your reference committee agrees that the resolution makes a valid point about how informational reports are notated and published. However, your Reference Committee believes that there may be solutions beyond those suggested in the resolved clauses and recommends further study of this issue to prevent future problems and misunderstandings related to informational reports.

(13) RESOLUTION 605 - ORAL HEALTH

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 605 be referred for decision.

HOD ACTION: Resolution 605 referred for decision.

Resolution 605 calls upon our AMA to endorse Smiles for Life: A National Oral Health Curriculum.

Your Reference Committee heard uniformly positive testimony supporting this resolution. Your Reference Committee supports the intent of the resolution, but reminds our House of Delegates that our AMA does not endorse commercial ventures or programs. In order for our AMA to offer its support and use of its logo to the “Smiles for Life” curriculum, it must undergo the same corporate review process as any other program or entity the AMA is asked to officially support.

(14) RESOLUTION 601 - ENGAGING AND EMPOWERING OUR MEMBERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 601 not be adopted.

HOD ACTION: Resolution 601 not adopted.

Resolution 601 calls upon our AMA to develop appropriate AMA Bylaws language for consideration at the 2015 Interim Meeting that defines a process and workflow by which all individual AMA members in good standing may introduce resolutions directly to our House of Delegates without changing the rights and privileges of current House of Delegates members.

Resolution 601 also requests that a means to filter inappropriate and duplicative resolutions be devised along with education for all AMA members who seek to introduce resolutions as individuals.

Your Reference Committee heard mixed testimony on this resolution. Your Reference Committee supports the intent of the resolution to involve as many physicians in the policymaking process of our AMA as possible; however, procedures and processes are already in place to allow individual members to introduce new policy. The established practice of introducing new policy through members of our AMA House of Delegates serves as an important link between our AMA and individual member physicians. The delegate or alternate delegate is a key source of information on activities, programs, and policies of our AMA and also elicits suggestions for situations that might be addressed through policy implementation. The delegate or alternate delegate is expected to advocate constituent views within our House of Delegates.

Testimony also pointed out that allowing an individual member to introduce resolutions could overwhelm the processes in place and lengthen meeting times. A resolution introduced by individuals subsequently may not have anyone present at the meeting to speak for its adoption. In addition, a new process to credential individuals would need to be designed and implemented as would a new process that provides education on resolution writing and the process for introducing them.

Your Reference Committee encourages delegations to consult widely among their constituents, as recommended in the Speaker's Advisory Report, and encourages delegations to take diverse opinions into account when deliberating the business of our House of Delegates.

(15) RESOLUTION 602 - DONATING REIMBURSEMENTS TO THE AMERICAN MEDICAL ASSOCIATION FOUNDATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 602 not be adopted.

HOD ACTION: Resolution 602 referred.

Resolution 602 calls upon our AMA to explore using non-employee travel reimbursement worksheets to allow members of the Board of Trustees, councils, and sections the option of donating a tax-deductible portion, or the total amount, of their travel reimbursement to the AMA Foundation Minority Scholars Fund or other AMA Foundation program benefitting medical students.

Your Reference Committee appreciates the intent of this resolution to support our American Medical Association Foundation and heard testimony that also supported the overall intent. However, the proposed resolution has unintended financial, legal, and tax consequences, some of which were heard in testimony. The resolution's reference to a reimbursement worksheet could become a problem when the process of reimbursement becomes a virtual process and worksheets are no longer used. In addition, the resolution is prescriptive, focusing only on medical students when there are other causes supported by our AMA Foundation.

Your Reference Committee would like to remind delegates of the ease and benefits of donating to our AMA Foundation via the established process.

(16) RESOLUTION 603 - TRANSPARENCY OF ORIGINS IN THE CATALOGUE OF AMA POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 603 not be adopted.

HOD ACTION: Resolution 603 not adopted.

Resolution 603 calls upon our AMA to append sponsor names to resolutions that result in new or reaffirmation of AMA policy beginning with the business considered at the 2015 Annual Meeting.

Your Reference Committee heard mixed testimony on this resolution; however, mechanisms already exist to satisfy the intent of the resolution.

Every current policy in PolicyFinder includes an annotation or set of annotations pointing to the actions that led to the current version of that policy. These annotations refer back to the Proceedings of our House of Delegates, which are posted on the AMA website and will remain there indefinitely. By referring to the policy annotation(s) and the relevant Proceedings, the original sponsor(s) of a resolution can be identified. It is worth noting that adopted language may have been amended or substituted, and those amendments or substitutions could conceivably make the resolution considerably different and possibly unpalatable to the original sponsor. Several delegates testified that once adopted, a policy becomes the policy of the House of Delegates, not of an individual or a delegation.

(17) RESOLUTION 604 - A NEW DEFINITION OF "WOMEN'S HEALTH"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 604 not be adopted.

HOD ACTION: Resolution 604 referred.

Resolution 604 calls upon our AMA to embrace a more comprehensive definition of "women's health" to include all health conditions for which there is evidence in women, compared to men, of differing risks, presentations, and/or responses to treatment, as well as those reproductive issues exclusive to women.

Resolution 604 further calls upon our AMA to encourage members to incorporate evidence-based information regarding the impact of sex and gender into their daily practices.

Your Reference Committee supports the intent of this resolution, and heard extensive testimony as to how best to support this intent. In the end, many varying amendments were submitted that could not be reconciled with each other. This is a complex concept with multiple facets and evolving science that would benefit from broader consultation across our AMA. Your Reference Committee encourages those with an interest to collaborate and to present a clear and precise definition of women's health in a resolution at a future meeting.

(18) RESOLUTION 608 - FIDUCIARY RESPONSIBILITY AND THE AMA INTERIM MEETING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 608 not be adopted.

HOD ACTION: Resolution 608 not adopted.

Resolution 608 calls upon our AMA to immediately discontinue scheduling our AMA Interim Meeting of the House of Delegates outside of the contiguous United States, and immediately cancel any such meetings and find alternative venues.

Your Reference Committee heard mixed testimony on this resolution. Delegates testified that the expense of traveling to Hawaii for our AMA meeting is burdensome and that the appearance of a Hawaii meeting could be

misperceived. This testimony was countered by testimony from those in closer proximity to Hawaii who pointed out that their cost to travel to eastern states is burdensome to them. Information presented by our Board of Trustees showed that meetings in the Washington, DC, area are more expensive for our AMA than meetings in Hawaii, and our AMA has already contracted two future Washington meetings. Also, our AMA's ability to negotiate multi-year contracts with concessions would be negatively affected given our prior cancellations of Interim Meetings in Dallas (2018), Atlanta (2019), and three Annual Meetings moved from the Hilton Chicago to the Hyatt Regency.

(19) RESOLUTION 610 - REQUIREMENT THAT THERE BE NO DIMINUTION IN PHYSICIAN REPRESENTATION ON THE JOINT COMMISSION

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 and AMA appointees to The Joint Commission to ensure that a physician majority is maintained on The Joint Commission's Board of Commissioners.

Your Reference Committee heard testimony mainly opposing this resolution. The current structure of The Joint Commission was explained and clarified. It was pointed out that a review of the Commission's governance structure is currently underway and any recommendation of our House of Delegates for change in this structure would be premature.

Your Reference Committee believes the testimony indicated that our AMA and physicians are well-represented at The Joint Commission and that no changes to its governance policies should be proposed at this time.

(20) RESOLUTION 611 - REPORT TO AMERICAN MEDICAL ASSOCIATION BY THE AMA APPOINTEES TO THE JOINT COMMISSION

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 provide the House of Delegates with an annual report written by its appointees to The Joint Commission.

Your Reference Committee heard testimony indicating that our AMA Commissioners to The Joint Commission meet biannually with our AMA Board of Trustees in the interest of transparency. Testimony further indicated that our AMA Commissioners are physician colleagues who are working on behalf of our profession and their fiduciary responsibility to The Joint Commission would limit the amount of detail they could provide in a written annual report that is in the public domain.

(21) BOARD OF TRUSTEES REPORT 3 - AUDITOR'S REPORT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 3 be filed.

HOD ACTION: Board of Trustees Report 3 filed.

Board of Trustees Report 3 introduces our AMA's 2013 and 2014 Consolidated Financial Statements and an Independent Auditor's report, which are featured in a separate document titled, "2014 Annual Report" that was made available with the Handbook materials.

Only positive testimony was received in response to Board of Trustees Report 3. Your Reference Committee extends its appreciation to our Board of Trustees and staff for their ongoing efforts to maintain our AMA's solid financial position and membership gains. The close of 2014 marked the 14th time in the last 15 years that our AMA showed positive operating results, and it is the fourth consecutive year in which our AMA membership has grown.

Your Reference Committee wishes to remind our House of Delegates of the continuing commitment our Board of Trustees has made to regularly communicate our AMA's financial and membership statuses. In addition to the detailed presentation that occurs at the opening of the Reference Committee F hearing at each Annual meeting, the members of your Reference Committee meet, on behalf of the House of Delegates, four times a year with our Board of Trustees Finance Committee for continuous updates, explanations, and projections. This ongoing collaboration provides your Reference Committee with added insights into the complex business structures and dealings of our AMA.

REPORT OF REFERENCE COMMITTEE G

(1) BOARD OF TRUSTEES REPORT 17 - INCREASING PHYSICIAN EFFICIENCY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 17 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 17 adopted and the remainder of the report filed.

Board of Trustees Report 17 recommends that our AMA reaffirm Policies H-480.971, D-478.995 and D-478.976.

There was supportive testimony on this item. An amendment was offered addressing the relationship of electronic medical record implementation to patient safety and the financial solvency of physician practices, but your Reference Committee believes that the proposed amendment is outside the scope of Board of Trustees Report 17. Your Reference Committee notes that under the AMA's Professional Satisfaction and Practice Sustainability strategic focus area, the AMA has identified key challenges physicians face with current electronic health records (EHRs) and recommends eight EHR usability priorities. These priorities were developed in response to an AMA October 2013 study on physician satisfaction, done in collaboration with RAND Health, which found that EHRs are a major source of physician dissatisfaction. The AMA's eight EHR usability priorities reframe the discussion around the desired future capabilities of EHR, making clinical care improvements the primary focus. Additionally, the AMA has urged continued research to advance EHR usability through understanding and measuring its effectiveness for physicians and other health care professional users who increasingly rely on this technology. Your Reference Committee believes that the policies recommended for reaffirmation in Board of Trustees Report 17 support a blended approach to documentation within electronic health records that recognizes physician preference, practice patterns, document type and organizational imperatives for measuring performance and quality. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 17.

(2) COUNCIL ON MEDICAL SERVICE REPORT 8 - IMPROVING HOME HEALTH CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 8 adopted and the remainder of the report filed.

Council on Medical Service Report 8 recommends that our AMA support the appropriate training of home health aides to ensure the quality of services they provide; support regulatory oversight of home health agencies that employ home health aides; and work with interested state medical associations to support state legislation that requires home health aides to obtain appropriate training before caring for patients.

There was supportive testimony on Council on Medical Service Report 8. A member of the Council on Medical Service noted that requirements for competency evaluations for home health aides are already outlined in the Medicare Conditions of Participation (COPs). The COPs state that home health aides must complete a training program, as well as a competency evaluation program or state licensure program that ensures aptitude in key subject areas, or a competency evaluation program or state licensure program that ensures proficiency in the subject areas taught in training. The COPs state that the home health aide training program must total at least 75 hours, with at least 16 hours devoted to supervised practical training. Medicare COPs also require home health aides to receive ongoing training. After the initial training, the COPs dictate that home health aides must receive at least 12 hours of

in-service training during each 12-month period, and receive a performance review at least annually. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 8 be adopted.

(3) COUNCIL ON MEDICAL SERVICE REPORT 9 - MEDICATION ADMINISTRATION IN ASSISTED LIVING FACILITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Service Report 9
adopted and the remainder of the report filed.**

Council on Medical Service Report 9 recommends the reaffirmation of Policies H-280.999 and H-120.955, as well as support for medication administration by appropriately trained facility staff for residents of assisted living and dementia care facilities who require assistance in taking their medications.

There was supportive testimony on Council on Medical Service Report 9. A speaker offered an amendment in support of model state legislation that would call for competency-based learning for medication administration. Due to variation in state law addressing medication administration and scope of practice, your Reference Committee believes that drafting model state legislation may undermine some existing state laws. Your Reference Committee believes the recommendations of this report provide a good framework for medication administration in assisted living and dementia care facilities, which takes into consideration differences between patients and in state laws. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 9 be adopted.

(4) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REPORT OF 2005 HOUSE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be amended by addition on lines 35-36 to read as follows:

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of Policy D-445.998, which should be retained.

RECOMMENDATION B:

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

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

Council on Medical Service Report 1 contains recommendations to retain or rescind 2005 AMA socioeconomic policies.

Your Reference Committee heard generally supportive testimony on Council on Medical Service Report 1. However, there were two suggested amendments to the report. First, an amendment was offered to retain H-185.959[2]. Your Reference Committee believes that the report's recommendation to rescind H-185.959[2] is

appropriate, as medical savings accounts were discontinued with the end of the limited Archer MSA pilot. The end of the pilot coincided with the passage in 2003 of the Medicare Prescription Drug, Improvement, and Modernization Act, which established more expansive health savings accounts. Another speaker believed that D-445.998, which strongly encourages the media to require that the actual degree be affixed to the name of all who endorse health-related products, is still relevant. Your Reference Committee agrees, and therefore recommends adoption of Council on Medical Service Report 1 as amended.

(5) COUNCIL ON MEDICAL SERVICE REPORT 4 - PRICE TRANSPARENCY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Council on Medical Service Report 4 be amended by deletion to read as follows:

2. That our AMA encourage physicians to ~~develop fee schedules that allow them or their designees to communicate~~ information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 4 be amended by addition of a new Recommendation to read as follows:

That our AMA request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 4 recommends ways to expand the availability of health care pricing information that will allow patients and their physicians to make value-based decisions.

There was generally supportive testimony on this report. A speaker testified that referred Resolution 819-I-14 also called for transparency of Part B hospital payments, which was not included in the recommendations of Council on Medical Service Report 4. Your Reference Committee believes that Part B hospital outpatient payments could be added to the Medicare Physician Fee Schedule Look-up Tool to improve transparency. Speakers also highlighted concerns with the second recommendation of the report that encourages physicians to develop fee schedules to communicate information about the cost of their professional services to individual patients. Your Reference Committee believes that physicians must be a part of the national conversation on price transparency, but suggests amended language to the second recommendation that is less prescriptive and responds to unique circumstances of employed physicians. There was also an amendment offered to require health plans to provide patients with benefits and real-time cost-sharing information, but your Reference Committee believes that the existing language of the third recommendation adequately addresses concerns raised in testimony. Your Reference Committee welcomes testimony offered by a member of the Council on Medical Service that the Council will continue to monitor this issue and will report back as appropriate. As such, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted.

(6) RESOLUTION 702 - ACCESS TO IN-OFFICE ADMINISTERED DRUGS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 702 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate that physician access to in-office administered drugs, including drugs dispensed by pharmacies, be preserved; and be it further

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 our AMA advocate for coverage for in-office administered drugs and related delivery services for patients who are physically unable to self-administer the drug.

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 advocate that physician access to in-office administered drugs be preserved; and work with CMS, Joint Commission, America's Health Insurance Plans, Federation of State Medical Boards, National Association of Boards of Pharmacy, and other involved stakeholders to improve and support patient access to in-office administered drugs.

Your Reference Committee heard supportive testimony on Resolution 702. One of the sponsors of Resolution 702 offered language to clarify the intent of the resolution, which your Reference Committee accepted. As such, your Reference Committee recommends that Resolution 702 be adopted as amended.

(7) RESOLUTION 704 - VIRTUAL CREDIT CARD PAYMENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 704 be adopted.

RESOLVED, That our American Medical Association (AMA) educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House; and be it further

RESOLVED, That our AMA advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards; and be it further

RESOLVED, That our AMA support transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician

consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

HOD ACTION: Substitute Resolution 704 adopted.

Resolution 704 asks that our AMA educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via an automated clearinghouse. The resolution also asks our AMA to advocate for transparency in the form of disclosure that accompanies payments or notices of payments from third party payers, including but not limited to the total amount of any transaction fees and the portion that is rebated to the payer or agents of transaction.

There was supportive testimony on this resolution. Speakers stressed that physicians must be given a choice to opt in to virtual credit card payments, and virtual credit card payments should not be used by payers without the express consent of physicians. Your Reference Committee notes that the AMA has been actively engaged on this issue. The AMA has a virtual credit card one-page resource, which is available online as part of the AMA's EFT Toolkit. Also, the AMA has model state legislation on this issue, the Transparency in Health Insurer Payment Transactions Act. While your Reference Committee concurs that physicians should be informed of the fees associated with virtual credit cards, payers do not have information regarding the total amount of fees that the physician will be charged, as this is dependent upon the physician's merchant agreement with the credit card company. As such, your Reference Committee recommends substitute language for the second Resolve. The third Resolve of the substitute resolution establishes foundational policy concerning payers' use of virtual credit card payments.

(8) RESOLUTION 709 - REQUIRING THE JOINT COMMISSION TO CONDUCT ROOT-CAUSE ANALYSIS TO DETERMINE HOW ITS SURVEYS ALLOWED VETERANS ADMINISTRATION HOSPITALS TO CAUSE DELAY IN TREATMENT AND HARM VETERANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 709 be adopted.

RESOLVED, That our AMA support The Joint Commission making public its findings following its resurveying of Veterans Health Administration (VHA) facilities to ensure quality of care and patient safety; and be it further

RESOLVED, That our AMA reaffirm Policies H-510.986 and D-510.994.

HOD ACTION: Substitute Resolution 709 adopted.

Resolution 709 asks that our AMA urge The Joint Commission to conduct root-cause analysis to determine how its surveys failed to uncover deficiencies that caused delay in treatment and resulted in harm to veterans at certain VA hospitals, and to take corrective action to prevent this in the future. The resolution also asks that our AMA appointees to The Joint Commission encourage it to present their findings in a report to the AMA Board of Trustees on the progress that is being made to ensure that its survey process corrects the deficiencies that allowed the delay in treatment and harm to veterans, with the report ultimately being provided to the House for its consideration.

There was mixed testimony on this resolution. The Joint Commission testified that it is necessary to provide Joint Commission surveyors with accurate information to ensure surveys are accurate and reliable. Speakers stressed that The Joint Commission is responsible for the quality of care to inpatients, not outpatients, and that the quality of care and patient safety issues highlighted occurred at VHA outpatient facilities. Testimony also highlighted that the VA Office of Inspector General and the Department of Justice is conducting an investigation into this matter. A speaker stated that The Joint Commission reached out to VHA to determine possible causes of the problems experienced at

VHA facilities, and that The Joint Commission will resurvey all of the VHA institutions again over a period of two years. Your Reference Committee believes that the findings of the surveys of the VHA facilities by The Joint Commission should be made public to ensure that veterans will not have future issues receiving timely, quality care. Your Reference Committee also believes that existing AMA policy addressed timely access to quality care for veterans should be reaffirmed. Accordingly, your Reference Committee recommends that Substitute Resolution 709 be adopted.

H-510.986 Ensuring Access to Care for our Veterans

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans. 2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner. 3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans. 4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

D-510.994 Health Care for Veterans and Their Families

Our AMA will : (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.

(9) RESOLUTION 710 - NOTIFICATION TO PHYSICIANS REGARDING COBRA GRACE PERIOD

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 710 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~work with Congress to require a advocate for~~ notification to physicians where patients are within the 45-day or 30-day COBRA grace periods in a manner similar to the ACA-required insurance marketplace 90-day notifications to physicians and, if possible, require such information to be provided in real-time.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 710 be adopted as amended.

HOD ACTION: Resolution 710 adopted as amended.

Resolution 710 asks that our AMA work with Congress to require a notification to physicians where patients are within the 45-day or 30-day COBRA grace periods in a manner similar to the ACA-required insurance marketplace 90-day notifications to physicians and, if possible, require such information to be provided in real-time.

There was supportive testimony on Resolution 710. Your Reference Committee recommends that Resolution 710 be adopted as amended to encompass the range of advocacy avenues that may be necessary to implement notification processes to physicians serving patients insured by COBRA continuation health coverage, including regulatory activities.

(10) RESOLUTION 711 - PROTECTING AGAINST FORCED NETWORK EXCLUSIVITY OF SPECIALIST PHYSICIANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 711 be adopted.

RESOLVED, That our American Medical Association reaffirm Policy H-285.989; and be it further

RESOLVED, That our AMA reaffirm Policy H-160.915; and be it further

RESOLVED, That our AMA support allowing specialty physicians to have primary contract status in more than one network.

HOD ACTION: Substitute Resolution 711 adopted.

Resolution 711 asks that our AMA advocate for legislation or regulation that would prohibit or render unenforceable any accountable care organization or integrated network, network-to-physician contract terms that require specialist physician participation in all risk contracts held by that network; and asks that our AMA prohibit or render unenforceable contract terms that specifically require specialist physicians to contract exclusively with one particular provider network, allowing primary contracting status in more than one network.

Your Reference Committee heard generally supportive testimony on Resolution 711. However, speakers raised concern that the wording of the first Resolve may have unintended consequences. Your Reference Committee notes that the intent of the first Resolve of Resolution 711 is addressed by existing AMA Policies H-285.989 and H-160.915. Your Reference Committee also offers substitute language for the second Resolve to clarify the intent of the Resolve clause, to avoid situations where networks can compel specialist exclusive participation, rather than prohibiting a specialist physician from entering into an exclusive contract if he or she wants to do so. Accordingly, your Reference Committee recommends that Substitute Resolution 711 be adopted.

H-285.989 AMA Opposition to All Products Clauses

Our AMA will seek legislative action to prohibit tying a physician's membership in an insurance product (e.g., a PPO) to that physician's participation in any other insurance product (e.g., an HMO, workers' compensation, automobile personal injury protection insurance, Medicare and Medicaid).

H-160.915 Accountable Care Organization Principles

Our AMA adopts the following Accountable Care Organization (ACO) principles: ... 3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff. ...

(11) RESOLUTION 713 - INCLUDE TELEMEDICINE IN THE DEFINITION OF DIRECT SUPERVISION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 713 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services ~~update revise~~ its "incident to" billing policy ~~direct supervision requirements to change the definition of direct supervision to~~

include virtual supervision via real-time telemedicine-based visual and audio interaction between the supervising physician and the non-physician providing patient care services, if rendered in accordance with other applicable federal and state laws and regulations.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 713 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 713 be changed to read as follows:

“INCIDENT TO” BILLING FOR TELEHEALTH

HOD ACTION: Resolution 713 referred.

Resolution 713 asks that our AMA request that the Centers for Medicare & Medicaid Services update its direct supervision requirements to change the definition of direct supervision to include supervision via real-time telemedicine-based visual and audio interaction, rendered in accordance with applicable federal and state laws and regulations.

Your Reference Committee heard mixed testimony on Resolution 713. Speakers raised concern with the unintended consequences of Resolution 713 pertaining to scope of practice and the supervision of residents and fellows. Testimony also raised concerns with expanding the definition of “direct supervision,” and stressed the need to differentiate between cognitive and procedural supervision. The Council on Medical Service offered an amendment to clarify the intent of the resolution. As such, your Reference Committee recommends that Resolution 713 be adopted as amended.

(12) RESOLUTION 714 – HOSPITAL ADMISSION PROCESSES AND COMMUNICATION BETWEEN PATIENTS’ PRIMARY CARE AND HOSPITAL-BASED PHYSICIANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 714 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate that hospital admission processes should include: (1) a determination of whether the patient has an existing relationship with an actively treating physician (primary care and/or specialty) a primary care physician; and (2) prompt notification of the patient’s actively treating physician (primary care/specialty) primary care physician, where such a relationship is found to exist and where the patient does not object to such notification.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 714 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA reaffirm Policy D-160.945.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 714 be adopted as amended.

HOD ACTION: Resolution 714 referred.

Resolution 714 asks that our AMA advocate that hospital admission processes should include a determination of whether the patient has an existing relationship with a primary care physician; and prompt notification of the patient's primary care physician, where such a relationship is found to exist and where the patient does not object to such notification.

There was supportive testimony on Resolution 714. Speakers stressed that a patient's specialist physicians who are actively treating the patient should also be notified as part of hospital admissions processes. Testimony noted that communication between hospitals and a patient's physicians should also occur during the discharge process; your Reference Committee notes that Policy D-160.945 addresses the intent of such testimony. There also was support for including emergency room visits and notification of death of a patient in Resolution 714. However, your Reference Committee believes that such notification is outside the scope of the resolution. Your Reference Committee recommends that Resolution 714 be adopted as amended.

D-160.945 Communication Between Hospitals and Primary Care Referring Physicians

Our AMA: (1) advocates for continued Physician Consortium for Performance Improvement® (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings; (2) advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety; (3) will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process; (4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality; and (5) will explore new mechanisms to facilitate and incentivize communication and transmission of data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) between the hospital-based physician and the primary physician.

(13) RESOLUTION 715 – MEDICAL SERVICES – BILLING AND COLLECTING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 715 be adopted.

RESOLVED, that our AMA modify Policy H-185.944 by addition to read as follows:

Our AMA : (1) urges any pertinent official or governmental agency to require health insurance plans to issue identification cards to its subscribers which prominently identify the full legal name of the insured; name of the policy holder; identification numbers needed for claim submission; and the primary insurance company name with its appropriate mailing address; and (2) will advocate for legislative and regulatory sanctions against insurance companies which present obstacles to the timely filing of claims which result in the denial of benefits; and be it further

RESOLVED, That our AMA reaffirm Policy D-185.999; and be it further

RESOLVED, That our AMA reaffirm Policy H-190.959.

HOD ACTION: Substitute Resolution 715 adopted.

Resolution 715 asks that our AMA work with the American Association of Health Plans to ensure that insurance cards include a set of outlined information; and work with all interested parties to encourage third-party payers to furnish providers with easy, computer-based access to patient coverage information and to ensure that when a provider verifies a patient's coverage via such computer systems, third-party payers guarantee payment for valid services performed within 30 days of verification, upon submission of a clean claim.

There was limited yet supportive testimony on this resolution. However, your Reference Committee notes that existing policy addresses much of the intent of Resolution 715. Your Reference Committee recommended the modification of Policy H-185.944 to include provisions of Resolution 715 that are not already included in AMA policy. As such, your Reference Committee recommends that Substitute Resolution 715 be adopted.

D-185.999 Information Included On Health Insurance Identification Cards

Our AMA will continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing.

H-190.959 Physician Reimbursement by Health Insurance and Managed Care Companies

(1) Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days. (2) When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim. (3) Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.

(14) RESOLUTION 705 - PRE-AUTHORIZATION SIMPLIFICATION AND STANDARDIZATION
 RESOLUTION 712 - INCREASING PRIOR AUTHORIZATION REQUIREMENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 705 and 712 be referred.

HOD ACTION: Resolutions 705 and 712 referred.

Resolution 705 asks that our AMA study and develop best practices recommendations for simplification and timeliness of preauthorization and admission notifications, and report back to the House at the 2015 Interim Meeting, specifying that the best practices recommendations should include timely and binding preauthorization procedures for expensive procedures when requested by a physician or a patient. After adoption of the I-15 report, Resolution 705 asks that our AMA advocate that NCQA, URAC, and ERISA adopt these recommendations. Resolution 705 also asks that our AMA study all options including the option for developing a single interactive, browser-based portal for pre-authorization or admission notification and report back to the House at the 2015 Interim Meeting.

Resolution 712 asks that our AMA study the burdens imposed upon physician practices and patients as a result of growing requirements by payers to obtain prior authorization for medications, other forms of treatment, diagnostic procedures and referrals, and include in its study possible solutions. The resolution also asks that our AMA consider the inclusion of prior authorization requirements in the AMA's Physician Satisfaction and Practice Sustainability strategic focus, as well as the development of possible model state legislation that allows physicians to bill payers or benefit managers for the time and resources spent in compliance with prior authorization requirements, and model state legislation that prohibits retroactive rescission of prior authorization or clawback of reimbursement after prior authorization has been given, provided that information for the prior authorization was not fraudulent.

There was generally supportive testimony on Resolutions 705 and 712. A member of the Board of Trustees testified that Board of Trustees Report 11-A-15 outlines the administrative burden time study already underway and being jointly managed by the AMA Physician Satisfaction and Practice Sustainability and Advocacy Groups. In addition, there is already relevant model state legislation, the Ensuring Transparency in Prior Authorization Act, which would prevent utilization review entities from revoking or restricting a prior authorization for a period of 45 working days from the date the health care provider received the prior authorization. Overall, your Reference Committee is supportive of the intent of Resolutions 705 and 712 and believes that our AMA should study and develop prior authorization best practices that will reduce patient care delays and administrative burdens for physicians and address issues outlined in both resolutions. However, your Reference Committee also notes that there are aspects to both resolutions that are already addressed by AMA policy, model state legislation and other AMA activities. As such, your Reference Committee recommends referral to ensure a study on prior authorization is conducted that builds off, rather than duplicates, existing AMA efforts and activities.

(15) RESOLUTION 707 - PAIN AS THE FIFTH VITAL SIGN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be referred.

HOD ACTION: Resolution 707 referred.

Resolution 707 asks that our AMA adopt as policy the position that the clinical highlighting of pain as “fifth vital sign” and a focus on eradication or total resolution of a patient’s pain is misguided and leads to 1) inappropriate pain management demands by patient; 2) inappropriate pressure on clinical pain management practices by clinicians; and 3) consequently, the diffuse overuse of opioids. The resolution also asks that our AMA recommend that “pain as the fifth vital sign” be removed from the clinical practice environment, and encourage The Joint Commission remove “pain as the fifth vital sign” from its standards.

There was mixed testimony on this resolution. Speakers noted that “pain as the fifth vital sign” has never been a part of The Joint Commission standards. Testimony also highlighted concerns with current patient satisfaction measures connected to pain management and elimination. Several speakers emphasized the need for comprehensive pain assessment and treatment and to address clinical aspects of pain, including quality of care, access to care, and stigma issues. Testimony highlighted ongoing efforts by the AMA Taskforce to Reduce Opioid Abuse, an AMA-convened working group of representatives from more than 40 specialty and state medical associations. There were numerous calls for referral; a member of the Board of Trustees welcomed referral. As such, your Reference Committee recommends that Resolution 707 be referred.

(16) RESOLUTION 708 - “INCIDENT TO” BILLING AND NPI NUMBERS ON CLAIMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 708 be referred.

HOD ACTION: Resolution 708 referred.

Resolution 708 asks that our AMA work to eliminate “incident to” billing so that all charges to patients accurately reflect the practitioners’ care to avoid misrepresentation on a medical claim that the physician provided services, which will result in all payments being relevant to the skills and qualifications of the rendering practitioner. The resolution also asks that our AMA work to ensure all National Provider Identifiers (NPI) on a claim form accurately reflect the practitioner who provided the care rather than reporting under the physician’s NPI while maintaining that all such reimbursement be paid to physicians or their institutions.

Your Reference Committee heard mixed testimony on Resolution 708. There was strong support in maintaining “incident to” billing, and testimony that underscored that the supervision provided by physicians in this construct

has value. Nevertheless, the complexity of this issue demands further study. There were numerous calls for referral, as speakers noted that a report back would allow for additional education on this issue. As such, your Reference Committee recommends referral of Resolution 708.

(17) RESOLUTION 716 – PRINCIPLES FOR MEASURING AND REWARDING PHYSICIAN PERFORMANCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 716 be referred.

HOD ACTION: Resolution 716 referred.

Resolution 716 asks that our AMA study and consider adopting as policy the proposed “Principles for Measuring and Rewarding Physician Performance.”

Your Reference Committee heard mixed testimony. There were several calls for referral due to the length of the resolution, and lack of time for delegates to review the content in its entirety. Your Reference Committee agrees with calls for referral, as there are legitimate concerns with including the language that the AMA is considering to adopt in the Policy Database. Testimony also highlighted concerns with reporting back by the 2015 Interim Meeting due to the thorough vetting necessary of the proposed principles and the need to involve other entities including the Physician Consortium for Performance Improvement. As such, your Reference Committee recommends that Resolution 716 be referred.