

**MEMORIAL RESOLUTIONS  
ADOPTED UNANIMOUSLY**

**Michael J. Davidson, MD  
Introduced by the American College of Cardiology**

Whereas, Michael J. Davidson, MD was an innovative cardiac surgeon and director of endovascular cardiac surgery at Brigham and Women's Hospital; and

Whereas, Dr. Davidson earned his MD degree from Yale University in 1996 and completed his surgical residency as well as his cardiac surgical fellowship and endovascular interventional training at Duke University and Brigham and Women's Hospital; and

Whereas, Dr. Davidson was one of only a handful of cardiac surgeons trained in endovascular approaches to complex structural heart disease procedures; and

Whereas, Dr. Davidson was a visionary who orchestrated many of Brigham and Women's Hospital's first ever complex structural heart procedures including the first "valve-in-valve" tricuspid valve replacement; and

Whereas, Dr. Davidson was instrumental in creating Brigham and Women's Hospital's first hybrid operating room suite which allowed for complex procedures to be performed by a team of surgeons and interventional cardiologists; and

Whereas, Dr. Davidson was a talented surgeon willing to operate on the sickest and most frail patients; and

Whereas, Dr. Davidson was an incredible mentor and teacher to the surgical and interventional cardiology residents and fellows at Brigham and Women's Hospital; and

Whereas, Dr. Davidson was a compassionate and empathetic physician attentive to every need of his patients and their families; and

Whereas, Dr. Davidson even spent the last moments of his life trying to calm a distraught patient's family member; and

Whereas, Dr. Davidson had his life taken from him at the age of 44 while at work in the hospital serving his patients on January 20, 2015; therefore be it

RESOLVED, That our American Medical Association recognize the life-long service of Doctor Michael J. Davidson to his community, his patients, and his profession and convey this resolution and its deepest sympathy to the family of Doctor Michael J. Davidson.

**Irwin Schatz, MD  
Introduced by the American College of Cardiology and Hawaii Medical Association**

Whereas, Irwin Schatz MD, FACC was the highly regarded chairman of medicine and professor at the John A. Burns School of Medicine in Honolulu, HI; and

Whereas, Dr. Schatz earned undergraduate and medical degrees from the University of Manitoba, subsequently training at the Henry Ford Hospital in Detroit and the Mayo Clinic in Rochester; and

Whereas, In 1965, just four years after graduating from medical school, Dr. Schatz bravely wrote a letter of concern to the US Public Health Service and the editor of the Archives of Internal Medicine regarding publication of an article in the December 1964 issue of the Archives describing a syphilis experiment using uneducated black men in Tuskegee, AL; and

Whereas, Dr. Schatz stood virtually alone in his protest in 1964: “I couldn’t believe what I had read. But the message was unmistakable. These researchers had deliberately withheld treatment for this group of poor, uneducated, black sharecroppers in order to document what eventually might happen to them. I became incensed. How could physicians, who were trained first and foremost to do no harm, deliberately withhold curative treatment so they could understand the natural history of syphilis;” and

Whereas, Neither the US Public Health Service, nor the authors of this paper or the Editors of the Archives of Internal Medicine ever responded to Dr. Schatz’ letter; and

Whereas, Our American Medical Association encourages all physicians to personally confront establishment authorities engaged in unethical practices as exhibited by Dr. Schatz’ actions as a young physician; and

Whereas, Our AMA celebrates the spirit of uncompromising service to patients exemplified by Dr. Schatz during his long career in medicine; therefore be it

RESOLVED, That our American Medical Association convey this resolution and its deepest sympathy to the family of Doctor Irwin Schatz.

## RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, June 7. The following resolutions were handled on the reaffirmation calendar: 102, 104, 109, 113, 118, 123, 205, 206, 209, 212, 217, 220, 226, 403, 405, 410, 411, 415, 418, 422, 509, 518, 520, 521, 701, 703 and 706.

### 1. RULES FOR AMA ELECTIONS

**Introduced by Andrew W. Gurman, MD, Delegate, Pennsylvania; and Susan R. Bailey, MD, Delegate, Texas**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

#### HOUSE ACTION: ADOPTED AS FOLLOWS

*See Policy G-610.020*

RESOLVED, That Policy G-610.020 be amended by addition and deletion to read as follows:

(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker, is responsible for declaring a violation of the rules;

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. The Speakers may use additional means to make delegates aware of those members intending to seek election;

(3)(4) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

(4)(2) An Election Manual ~~campaign manual~~ containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur, and distributed; The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(3) Campaign expenditures and activities should be limited to prudent and reasonable levels necessary for adequate candidate exposure to the delegates. The Speaker of the House should meet with all announced candidates and campaign managers at each meeting of the House of Delegates to agree on general campaign procedures;

(5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;

~~(6)(4)~~ At the Interim Meeting, campaign-related expenditures and activities shall be discouraged, ~~and there shall be no large~~ Large campaign receptions, luncheons, or other formal campaign activities. ~~This rule does not preclude distribution of a declaration of candidacy on the last day of the Annual Meeting, last day of the Interim Meeting, or one announcement of candidacy by a mailing prior to the Interim Meeting. An announcement of candidacy includes only the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. This rule prohibits campaign parties at the Interim Meeting and the distribution of campaign literature and gifts are prohibited~~ at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election ~~at the next Annual Meeting~~ to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;

~~(7)(5)~~ 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; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

~~(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, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;

~~(9)(7)~~ Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited. ~~Displays of campaign posters, signs, and literature in public areas of hotels in which Annual Meetings are held~~ because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business ~~folder~~ bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

~~(8)~~ A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings;

~~(10)(9)~~ Campaign expenditures and activities should be limited to 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;

~~(11)(10)~~ The Speaker's office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

~~(13)(11)~~ Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;

(14) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;

(15)(13) Our AMA (a) requires completion of ~~Disclosure of Affiliation~~ conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed ~~Disclosure of Affiliation~~ conflict of interest information by posting such information on the “Members Only” section of the our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

## 2. AMA PARLIAMENTARY AUTHORITY

**Introduced by Andrew W. Gurman, MD, Delegate, Pennsylvania; and Susan R. Bailey, MD, Delegate, Texas**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED  
BYLAWS AMENDED**  
*See Bylaw 11.1*

RESOLVED, That American Medical Association Bylaw 11.1 be amended by addition to read as follows:

Parliamentary Procedure. In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

## 3. PROPOSED REVISIONS TO THE BYLAWS OF THE AMA SECTION ON MEDICAL SCHOOLS

**Introduced by Donald G. Eckhoff, MD, Delegate, Section on Medical Schools**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy G-615.007*

RESOLVED, That our American Medical Association Section on Medical Schools (AMA-SMS) be renamed the American Medical Association Academic Physicians Section (AMA-APS); and be it further

RESOLVED, That our AMA Bylaws be further revised to clarify membership criteria for the AMA-APS, as follows: 1) appointment by the dean of any United States medical school with an educational program as defined in Bylaw 1.1.1.1.b., to represent undergraduate, graduate or continuing medical education at the institution; 2) self-designation as an academic physician, as defined in the AMA Bylaws; or 3) self-nomination as a physician who does not hold a medical school faculty appointment but has an active role in student (undergraduate), resident/fellow (graduate), and/or faculty (continuing) medical education or serves in a clinical/research capacity with an academic medical center, community hospital, or other health care setting”; and be it further

RESOLVED, That our AMA Bylaws be further revised to eliminate the provisional member category of the AMA-APS and the term “representative to the business meeting.”

**4. CONFIDENTIALITY OF ENROLLMENT IN PHYSICIANS  
(PROFESSIONAL) HEALTH PROGRAMS  
Introduced by Louisiana**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy D-405.984*

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 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 programs or their recovery programs in responding to questions on medical practice or licensure applications; and further be it

RESOLVED, That our AMA work with The Joint Commission, national hospital association, 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 programs and who do not constitute a current threat to the care of themselves or their patients.

**5. PRINCIPLES OF HUMAN SUBJECTS RESEARCH SHALL APPLY TO  
ONLINE MEDICAL RESEARCH PROJECTS  
Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy H-460.898*

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 any medical experiment; and be it further

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

**6. PHYSICIAN AND HEALTH INSTITUTION PUBLICITY AND RESPONSIBILITY  
Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-445.985*

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 published peer-reviewed evidence, standard of care, or personal opinion.

**7. VACCINATION REQUIREMENTS TO PROTECT ALL CHILDREN**  
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-440.832*

RESOLVED, That our American Medical Association 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

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.

**8. PROTECTING PATIENTS AND THE PUBLIC BY IMMUNIZING PHYSICIANS**  
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-440.831*

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.

**9. PARENT TO PARENT EDUCATION ON CHILD VACCINATION**  
**Introduced by California**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED**

*See Policy H-440.830*

RESOLVED; That, in order to increase child vaccination rates, our American Medical Association support the development and evaluation of educational efforts, based on scientific evidence and in collaboration with health care providers, that support parents who want to help educate and encourage parents reluctant to vaccinate their children.

**10. ENDING NON-MEDICAL EXEMPTIONS FOR IMMUNIZATION**  
**Introduced by American Academy of Pediatrics**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED**

*See Policies H-440.829 and H-440.970*

RESOLVED, That our American Medical Association reaffirm AMA Policy H-440.970, Religious Exemptions from Immunizations; and be it further

RESOLVED, That our AMA support legislation eliminating non-medical exemptions from immunization for participation in federally funded educational programs for children including Head Start; and be it further

RESOLVED, That our AMA support state medical society efforts to eliminate non-medical exemptions from immunization for childcare and school attendance in state statutes.

**11. MILITARY MEDICAL POLICIES AFFECTING TRANSGENDER INDIVIDUALS**  
**Introduced by Gay and Lesbian Medical Association, American Psychiatric Association,  
American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law,  
American Academy of Neurology and Massachusetts**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED**

*See Policy H-40.966*

RESOLVED, That our American Medical Association affirm that there is no medically valid reason to exclude transgender individuals from service in the US military; and be it further

RESOLVED, That our AMA affirm transgender service members be provided care as determined by patient and physician according to the same medical standards that apply to non-transgender personnel.

**12. ENCOURAGE AUTISM SOCIETY TO SUPPORT VACCINATIONS**  
**Introduced by Iowa**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-440.931*

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 encourage the Autism Society of America to 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.

**13. FILMING PATIENTS FOR NEWS OR ENTERTAINMENT****Introduced by New York**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED**

*See Policy H-140.840*

RESOLVED, That our American Medical Association adopt policy which states that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) 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.

**14. PROMOTING SAFE EXIT FROM PROSTITUTION****Introduced by Texas**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED**

*See Policy H-515.958*

RESOLVED, That our American Medical Association support efforts to offer individuals a safe exit from prostitution in pursuit of compassionate care and best practices; and be it further

RESOLVED, That our AMA support legislation for programs that prevent and divert prostitution rather than penalize it through criminal conviction and incarceration.

**15. PROGRAMS ON MANAGING PHYSICIAN STRESS AND BURNOUT****Introduced by New York**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-405.957*

RESOLVED, That our American Medical Association support existing programs to assist physicians in early identification and management of stress; and be it further

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.

**16. ETHICAL PHYSICIAN CONDUCT IN THE MEDIA****Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).*

**HOUSE ACTION: ADOPTED**

*See Policy D-140.957*

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform; and be it further

RESOLVED, That our AMA release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media.

**101. INTEREST ON MEDICARE OVERPAYMENTS AND UNDERPAYMENTS**  
**Introduced by California**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy H-390.880*

RESOLVED, That our American Medical Association 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.

**102. ACTUAL ALLOWABLE BY MEDICARE**  
**Introduced by Louisiana**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-400.956, H-400.959 AND H-400.969 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association annually examine the “allowable” Medicare fee schedules (E&M and CPT code) to determine if the reimbursement is consistent with the government’s stated increase or decrease based on the SGR and alert its membership as to that consistency or lack thereof.

**103. THREE DAY STAY RULE**  
**Introduced by International College of Surgeons - US Section**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**  
**IN LIEU OF RESOLUTION 105**  
*See Policy H-280.947*

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 department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services.

**104. MEDICAID, CHILDREN'S HEALTH INSURANCE PROGRAM, AND VACCINES  
FOR CHILDREN PAYMENT REFORM  
Introduced by American Academy of Pediatrics**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-290.976, H-290.980 AND H-385.921 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association make it a high priority to convince Congress to assure that payment by state Medicaid, Children's Health Insurance Program (CHIP), and Vaccine for Children (VFC) programs is at least equal to the Medicare rate.

**105. EXPANDING MEDICARE'S THREE-DAY HOSPITAL STAY REQUIREMENT  
TO INCLUDE OBSERVATION HOURS  
Introduced by American Medical Group Association**

Resolution 105 was considered with Resolution 103. See Resolution [103](#).

RESOLVED, That our American Medical Association 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.

**106. CONTROLLING THE SKYROCKETING COSTS OF GENERIC PRESCRIPTION DRUGS  
Introduced by Pennsylvania**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED  
IN LIEU OF RESOLUTIONS 117, 124, 125 AND 127  
See Policy H-110.988**

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.

**107. REIMBURSEMENT FOR END-OF-LIFE COUNSELING**  
**Introduced by California**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: POLICY H-390.916 AMENDED  
IN LIEU OF RESOLUTION 107**

Policy H-390.916 amended by addition and deletion to read as follows:

H-390.916 Payment for Patient ~~Counseling Conferences~~ Regarding Advance ~~Care Planning Directives~~

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).

**108. SURVIVORSHIP CARE PLANS**  
**Introduced by California**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy H-55.969*

RESOLVED, That our American Medical Association support the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician; and be it further

RESOLVED, That our AMA support reimbursement for physician preparation of survivorship care plans for patients.

**109. MEDICARE COVERAGE OF PHYSICIAN ADMINISTERED MEDICATIONS  
PROCURED BY PATIENTS**  
**Introduced by California**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-330.888, H-330.897 AND D-330.960 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED That our American Medical Association support reimbursement to physicians that covers the cost of procuring and administering physician administered drugs (PAD), as defined by Medicare, in the Medicare program.

**110. REMOVAL OF THE REQUIRED THREE DAY STAY FOR PLACEMENT  
INTO SKILLED OR LONG-TERM CARE FACILITIES  
Introduced by Nebraska, North Dakota and Iowa**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-280.947*

RESOLVED, That our American Medical Association actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement.

**111. ACCESS TO HEALTH CARE FOR VETERANS  
Introduced by Florida**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED  
WITH CHANGE IN TITLE  
IN LIEU OF RESOLUTIONS 112, 114 AND 130**

*See Policy H-510.985*

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.

**112. IMPROVING TIMELY ACCESS TO QUALITY HEALTHCARE FOR AMERICA'S VETERANS  
Introduced by Florida**

Resolution 112 was considered with Resolutions 111, 114 and 130. See Resolution [111](#).

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, 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.

**113. THREE DAY STAY RULE**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-280.950, H-280.977 AND D-280.988 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association adopt as policy the goal of eliminating Medicare's requirement of a hospital inpatient admission as a condition of eligibility for receiving Medicare rehabilitation and nursing benefits in a skilled care facility.

**114. AN HSA CARD WILL GIVE VETERANS BETTER, FASTER HEALTH CARE**  
**Introduced by Illinois**

Resolution 114 was considered with Resolutions 111, 112 and 130. See Resolution [111](#).

RESOLVED, That our American Medical Association 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.

**115. SUPPORT FOR INCLUSION OF VASECTOMY IN THE ACA PREVENTIVE**  
**SERVICES AND CONTRACEPTIVE MANDATE**  
**Introduced by Washington**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**  
*See Policy H-185.932*

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.

**116. STUDY THE IMPACT OF THE ACA MEDICAID EXPANSION**  
**Introduced by California**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-290.976*

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, (b) the quality of health care services provided to those who are part of the Medicaid expansion population, (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

RESOLVED, That our AMA provide this report to the HOD at the 2016 Annual Meeting.

**117. PRICING OF GENERIC DRUGS**  
**Introduced by Missouri**

Resolution 117 was considered with Resolutions 106, 124, 125 and 127. See Resolution [106](#).

RESOLVED, That our American Medical Association 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.

**118. ECONOMIC FREEDOM OF CHOICE FOR PHYSICIANS**  
**Introduced by Douglas Myers, MD, Delegate, Washington**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-385.926, H-385.986 AND H-385.989 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association oppose attempts by the government to directly or indirectly compel physicians to participate in any payment methodology; and be it further

RESOLVED, That our AMA actively support our policy of maintaining a pluralistic healthcare payment system and protect the rights of American physicians to receive pay for the work that they perform under a variety of systems, including fee-for-service.

**119. OUT OF NETWORK COVERAGE DENIALS FOR PHYSICIAN PRESCRIPTIONS  
AND ORDERED SERVICES**  
**Introduced by New York**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy D-285.963*

RESOLVED, That our American Medical Association 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.

**120. HIGH DEDUCTIBLE, HIGH COINSURANCE POLICIES**  
**Introduced by Wisconsin**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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.

**121. FLEXIBLE SPENDING ACCOUNT AMOUNTS**  
**Introduced by Wisconsin**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-165.863*

RESOLVED, That our American Medical Association advocate for a reasonable increase in Section 125 Flex Spending accounts.

**122. CHRONIC DISEASES**  
**Introduced by Wisconsin**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: POLICIES H-155.960 AND H-185.939 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association 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.

**123. SITE OF SERVICE PARITY**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-240.979, H-240.993, H-330.925 AND D-330.997 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association seek legislation or regulation which would eliminate Medicare and commercial insurance payment differentials for physician services based upon site of service.

**124. REDUCING PRESCRIPTION DRUG PRICES**

**Introduced by Heart Rhythm Society, American College of Cardiology,  
American Society for Echocardiography and Society for Cardiovascular Angiography and Interventions**

Resolution 124 was considered with Resolutions 106, 117, 125 and 127. See Resolution [106](#).

RESOLVED, That our American Medical Association 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.

**125. RISING GENERIC DRUG PRICES**

**Introduced by Michigan**

Resolution 125 was considered with Resolutions 106, 117, 124 and 127. See Resolution [106](#).

RESOLVED, That our American Medical Association 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.

**126. OUT-OF-NETWORK RESTRICTIONS OF PHYSICIANS**

**Introduced by Maryland**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED**

*See Policy H-285.907*

RESOLVED, That our American Medical Association 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.

**127. CONTROLLING RAPIDLY ESCALATING GENERIC MEDICATION PRICES**

**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont**

Resolution 127 was considered with Resolutions 106, 117, 124 and 125. See Resolution [106](#).

RESOLVED, That our American Medical Association advocate that when there are significant price increases that negatively impact patient access to generic medication, then the Food and Drug Administration may waive or reduce entry fees and expedite approval process for other manufacturers to enter the market for that medication; and be it further

RESOLVED, 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.

**128. INCLUDE PHYSICIANS IN CMS RATE INCREASES TO MEDICARE ADVANTAGE PLANS**  
**Introduced by New Mexico**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**

*See Policy H-390.842*

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.

**129. MOVING TO ALTERNATIVE PAYMENT MODELS**  
**Introduced by Integrated Physician Practice Section**

*Reference committee hearing: see report of [Reference Committee A](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-450.931*

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

RESOLVED, That AMA, in partnership with other appropriate physician organizations, 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)

**130. ENSURING ENHANCED DELIVERY OF HEALTH CARE TO OUR NATION'S VETERANS**  
**Introduced by Organized Medical Staff Section**

Resolution 130 was considered with Resolutions 111, 112 and 114. See Resolution [111](#).

RESOLVED, That our American Medical Association continue its strong advocacy for safe, timely, and effective healthcare for all patients, including our nation's veterans; and be it further

RESOLVED, That as part of its commitment to safe, timely, and effective healthcare 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 healthcare to our nation's veterans.

**201. BEST PRACTICES FOR MOBILE MEDICAL APPLICATIONS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-480.972*

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

**202. MEASURING THE EFFECT OF PAID SICK LEAVE ON HEALTH CARE OUTCOMES**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; and be it further

RESOLVED, That our AMA 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.

**203. MODEL STATE LEGISLATION ELIMINATING RESTRICTIVE COVENANTS  
IN PHYSICIAN CONTRACTS**  
**Introduced by Virginia, Kentucky and South Carolina**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, 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.

**204. NOMINATION FOR AND IMPROVEMENT OF THE POSITION OF THE  
UNITED STATES SURGEON GENERAL**  
**Introduced by Delaware**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, 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 be it further

RESOLVED, That our AMA Board of Trustees appoint a task force comprised of former Surgeons General of the United States and other leaders within the public health community to consider how the position of US Surgeon General can be strengthened to better advocate for the health of the citizens of the United States; and be it further

RESOLVED, That 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.

**205. DOCTOR HOSPITAL OWNERSHIP**  
**Introduced by American College of Radiation Oncology, Arizona,**  
**American Society of General Surgeons, Arkansas and Florida**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-140.861, H-140.984 AND H-165.838 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association aggressively seek rescission of the federal prohibition on physician ownership of hospitals.

**206. TRADE DEALS MUST NOT THREATEN HEALTH OR ENVIRONMENT**  
**Introduced by American Association of Public Health Physicians**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY D-505.998 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association oppose any trade agreement that compromises Americans' ability to institute new health and environmental laws and rules; and be it further

RESOLVED, That our AMA advocate that Americans receive sufficient time, after the full text of any proposed international agreement becomes public, to consider the full implications (including health and environmental implications) of the agreement's actual provisions.

**207. APPROPRIATE USE OF COMPOUNDED MEDICATIONS IN MEDICAL OFFICES**  
**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery,**  
**American College of Mohs Surgery and Society for Investigative Dermatology**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-120.934*

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) purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use.

**208. REDUCE REPORTING BURDEN AND CONFUSION**  
**Introduced by J. Gregory Cooper, MD, Delegate, Kentucky**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: POLICIES H-450.966 AND D-478.995 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, 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."

**209. ICD-10 AND ICD-11**  
**Introduced by Louisiana**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY D-70.952 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association study the feasibility of waiting and adopting ICD-11 if it is found to be less burdensome upon providers.

**210. PHYSICIAN PARTICIPATION AS THE 5<sup>TH</sup> COOPERATING PARTY IN THE INTERNATIONAL**  
**CLASSIFICATION OF DISEASES SYSTEM IN THE UNITED STATES**  
**Introduced by Alabama**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-70.946*

RESOLVED, That our American Medical Association advocate for a group with strong physician participation to be the 5<sup>th</sup> 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

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.

**211. ICD-10 IMPLEMENTATION**  
**Introduced by Alabama**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**  
*See Policy D-70.945*

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.

**212. SUPPORT FOR EXPANDED FUNDING FOR NATIONAL, STATE AND LOCAL PUBLIC HEALTH**  
**Introduced by American Association of Public Health Physicians**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-100.980, H-130.946, H-170.980, H-170.986, H-420.986, H-440.847, H-440.851, H-440.888, H-440.912, H-440.928, H-440.939, H-440.954, H-440.982, D-130.966, D-170.994, D-440.944 AND D-440.997 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage Congress to increase federal budget allocations for The Centers for Disease Control and Prevention, the FDA, and other agencies within the Department of Health and Human Services which allocate funds to prevent, manage and treat public health related problems such as infectious illnesses, emergency preparedness and response, environmental hazards and exposure, and the health education of the US population; and be it further

RESOLVED, That our AMA, working in conjunction with state medical societies, encourage state legislatures to increase the funding through the state budgetary process for state and local Public Health Agencies for MCH, TB and other infectious diseases, immunization services, emergency response and preparedness, general health education, support for age appropriate health education within the school systems of the state, and for the expansion of public health and school health nurse positions in public health agencies and in the public school systems; and be it further

RESOLVED, That our AMA reaffirm its policy to encourage all governmental appointing authorities, governors, mayors and county supervisors, to appoint qualified public health trained and experienced physicians to leadership positions in the local and state public health agencies.

**213. TAMPERING WITH THE IN-OFFICE ANCILLARY SERVICES EXCEPTION**  
**Introduced by American Medical Group Association**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: POLICY D-270.995 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, 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.

**214. FUNDING FOR TEACHING HEALTH CENTER GRADUATE MEDICAL EDUCATION PROGRAM**  
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-305.955*

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 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.

**215. HEALTH CARE REFORM MODEL LEGISLATION**  
**Introduced by Pennsylvania**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: POLICIES H-165.833, H-165.835, H-165.838, D-165.938 AND D-165.940**  
**REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, 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.

**216. PREVENTING FIREARM-RELATED INJURY AND MORBIDITY IN YOUTH**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-145.996*

RESOLVED, That our American Medical Association identify and support the distribution firearm safety materials that are appropriate for the clinical setting.

**217. STOP THE IMPLEMENTATION OF ICD-10**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-70.916, D-70.948, D-70.949, D-70.951, D-70.952 AND D-70.960**  
**REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association use all available resources to immediately and vigorously engage the executive and legislative branches of the federal government in an effort to permanently stop the implementation of ICD-10.

**218. ACTION TO ENSURE ACCESS TO HEALTHCARE AND CHOICE OF PHYSICIAN  
Introduced by Florida**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: POLICIES H-380.987 AND H-383.992 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, 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.

**219. NEED TO CREATE A SPECIAL INSPECTOR GENERAL FOR MONITORING  
THE AFFORDABLE CARE ACT  
Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association support the creation of a special inspector general to oversee the implementation of the Affordable Care Act (ACA).

**220. CAMPAIGN TO PROMOTE TRANSPARENCY REGARDING HEALTHCARE PROVIDERS  
AND THE PHYSICIAN AS THE LEADER OF THE HEALTHCARE TEAM  
Introduced by Nebraska**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-405.969 AND D-35.982 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association conduct research, fund, and facilitate a campaign to educate the public on the physician as the leader of the health care team based on physician knowledge and training, and the roles/limitations of non-physicians; and be it further

RESOLVED, That our AMA educate the public on the importance of evidence based medicine to provide them with the knowledge necessary to make informed decisions when seeking healthcare solutions; and be it further

RESOLVED, That our AMA collaborate with state and specialty societies to provide medical guidelines and financial support to further increase the campaign's reach and effectiveness.

**221. QUALITY IMPROVEMENT IN CLINICAL / POPULATION HEALTH INFORMATION SYSTEMS  
Introduced by New York**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy D-478.974*

RESOLVED, 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.

**222. MEDICARE AND SEQUESTRATION**  
**Introduced by Ohio**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-165.941*

RESOLVED, That our American Medical Association take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments.

**223. AUTOMATIC TRACKING OF QUALITY INDICATORS**  
**Introduced by Ohio**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: POLICIES H-450.966 AND D-478.995 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, 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.

**224. ELECTRONIC MEDICAL RECORDS VENDOR ACCOUNTABILITY**  
**Introduced by Ohio**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, 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; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA establish policy that EMR vendors should be accountable for downtime that is related to vendor issues; and be it further

RESOLVED, That our AMA 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.

**225. MAKE SIMPLICITY THE FOREMOST CRITERIA FOR ANY CMS PROGRAM**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-155.956*

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

**226. PHYSICIAN INVOLVEMENT WITH HEALTH CARE RELATED BUSINESSES**  
**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-140.984, H-140.861 AND H-165.838 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support physician-owned health care businesses being held to the same business standards as non-physician-owned health care businesses; and be it further

RESOLVED, That our AMA seek legislative and regulatory changes at the federal level to allow physicians to create, own, and support health care related businesses; utilize all available tools inside and outside of their practices; and, refer patients to these businesses for medically necessary services.

**227. PARTIAL CREDIT FOR ELIGIBLE PROFESSIONALS FOR ACCOMPLISHING**  
**MEANINGFUL USE GUIDELINES**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, 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 be it further

RESOLVED, That our AMA 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.

**228. REPEAL COMPULSORY ELECTRONIC HEALTH RECORDS**  
**Introduced by Texas**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: REFERRED**

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 advocate that the United States Congress act rapidly to repeal compulsory electronic health records (EHRs) 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.

**229. PHYSICIAN SELF-MONITORING OF CONTROLLED SUBSTANCE PRESCRIPTIONS**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-95.975*

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 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.

**230. OPPOSING LINKING ABMS CERTIFICATION TO INTERSTATE  
LICENSURE AND TELEMEDICINE**  
**Introduced by Florida**

Resolution 230 considered with Resolutions 231 and 235. See Resolution [235](#).

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards 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 be it further

RESOLVED, That our AMA oppose the linkage of state or interstate licensure for telemedicine to Maintenance of Certification.

**231. OPPOSING THE FEDERATION OF STATE MEDICAL BOARDS INTERSTATE  
MEDICAL LICENSURE COMPACT**  
**Introduced by Michigan**

Resolution 231 considered with Resolutions 230 and 235. See Resolution [235](#).

RESOLVED, That our American Medical Association Policy D-275.994 be amended by addition and deletion to read as follows:

D-275.994 Facilitating Credentialing for State Licensure

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) ~~supports~~ opposes the FSMB Interstate Compact for Medical Licensure ~~and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption~~

~~by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.~~

**232. CHILD RESISTANT CAPS ON ENERGY DRINKS**  
**Introduced by New York**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy H-60.920*

RESOLVED, 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.

**233. IMMUNITY FROM FEDERAL PROSECUTION FOR PHYSICIANS RECOMMENDING CANNABIS**  
**Introduced by New York**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy H-95.938*

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

**234. PRESERVING FREE SPEECH AND CONFIDENTIALITY IN THE  
PHYSICIAN-PATIENT RELATIONSHIP**  
**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy H-373.995*

RESOLVED, 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.

**235. MOC PROVISIONS OF INTERSTATE MEDICAL LICENSURE COMPACT**  
**Introduced by American Association of Clinical Endocrinologists,  
American Academy of Allergy, Asthma & Immunology, American College of Rheumatology and  
The Endocrine Society**

*Reference committee hearing: see report of [Reference Committee B](#).*

**HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTIONS 230 AND 231**  
*See Policy D-275.955*

RESOLVED, 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.

### **236. VALUE BASED MODIFIER AND FLAWED DRUG COST ATTRIBUTION**

**Introduced by American College of Rheumatology,  
American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology,  
American College of Gastroenterology and American Society of Clinical Oncology**

*Reference committee hearing: see report of [Reference Committee B](#).*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-390.841*

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.

### **237. 96-HOUR RULE FOR CRITICAL ACCESS HOSPITALS**

**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of [Reference Committee B](#).*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-390.952*

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

RESOLVED, 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.

### **238. PROTECTING PHYSICIAN LED HEALTH CARE**

**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of [Reference Committee B](#).*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-35.966*

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 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.

**301. ALERTING PHYSICIANS TO DEADLINES FOR MAINTENANCE OF CERTIFICATION**  
**Introduced by Young Physicians Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy D-275.960*

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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.

**302. RE-EVALUATING KNOWLEDGE ASSESSMENT IN MAINTENANCE OF CERTIFICATION**  
**Introduced by Young Physicians Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy D-275.960*

RESOLVED, That our American Medical Association 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.

**303. AUTONOMY IN UTILIZATION OF CME FUNDS BY EMPLOYED PHYSICIANS**  
**Introduced by Young Physicians Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy D-305.965*

RESOLVED, That our American Medical Association 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.

**304. ADDRESSING THE INCREASING NUMBER OF UNMATCHED MEDICAL STUDENTS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-310.977*

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

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.

**305. EVALUATION OF DACA-ELIGIBLE MEDICAL STUDENTS, RESIDENTS, AND PHYSICIANS IN ADDRESSING PHYSICIAN SHORTAGES**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy D-350.986*

RESOLVED, That our American Medical Association 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.

**306. INCLUDING MILITARY HISTORY AS PART OF STANDARD HISTORY TAKING**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: POLICY H-295.874 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage the universal inclusion of military history in the standard history taking of all adults in civilian healthcare settings; and be it further

RESOLVED, That our AMA support the addition of military history training to undergraduate, graduate, and continuing medical education and the continued refinement of existing screening resources.

**307. POLICY AND ADVOCACY OPPORTUNITIES FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy H-295.953*

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

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

**308. REDUCING THE FINANCIAL AND EDUCATIONAL COSTS OF  
RESIDENCY/FELLOWSHIP INTERVIEWS  
Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE  
See Policy H-310.966**

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 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 such interviews.

**309. MAINTENANCE OF CERTIFICATION  
Introduced by Gregory L. Pinto, MD, Delegate, New York**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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.

**310. MITIGATION OF PHYSICIAN PERFORMANCE METRICS ON TRAINEE  
AUTONOMY AND EDUCATION  
Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED  
WITH CHANGE IN TITLE  
See Policy D-310.952**

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.

**311. SELECTING RESIDENTS TO BETTER REFLECT PATIENT DIVERSITY  
Introduced by International Medical Graduates Section and Minority Affairs Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: POLICIES H-350.960, H-350.969 AND H-350.970 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association 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 US patient population.

**312. MODEL GUIDELINES FOR EXPANSION OF RESIDENCY PROGRAMS**  
**Introduced by International Medical Graduates Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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.

**313. HUMAN TRAFFICKING REPORTING AND EDUCATION**  
**Introduced by Women Physicians Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-65.966*

RESOLVED, That our AMA help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

**314. MAINTENANCE OF CERTIFICATION AND CONTINUING EDUCATION**  
**Introduced by Pennsylvania**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED AND  
POLICY H-274.924 AMENDED**

*See Policy D-275.960*

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.

Policy H-275.924 amended by addition 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 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.

### 315. OBESITY EDUCATION

**Introduced by American Society of Bariatric Physicians, Colorado and  
American Association of Clinical Endocrinologists**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED  
IN LIEU OF RESOLUTION 326**

*See Policy D-440.980*

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; and be it further

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 316 was moved to Reference Committee B. See Resolution [230](#).**

### 317. PROTECT PHYSICIAN CERTIFICATION AND LICENSURE

**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association 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.

### **318. MAINTENANCE OF CERTIFICATION**

**Introduced by American College of Cardiology, Society for Cardiovascular Angiography and Interventions,  
American Society for Echocardiography and Heart Rhythm Society**

*Reference committee hearing: see report of [Reference Committee C](#).*

#### **HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association congratulate the American Board of Medical Specialties (ABMS) and its member Boards on their century of service to our profession and our patients; and be it further

RESOLVED, That our American Medical Association 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.

### **319. PROMOTING TRANSPARENCY IN MEDICAL EDUCATION AND ACCESS TO TRAINING**

**Introduced by Washington**

*Reference committee hearing: see report of [Reference Committee C](#).*

#### **HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE See Policy H-295.860**

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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.

### **320. POST-ACUTE AND LONG-TERM CARE EDUCATION REQUIREMENT**

**Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine**

*Reference committee hearing: see report of [Reference Committee C](#).*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS See Policy H-280.999**

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

**321. VALUE OF RESIDENTS AND FELLOWS TO THE HEALTH CARE SYSTEM**  
**Introduced by Texas**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: FIRST RESOLVE ADOPTED**  
**SECOND RESOLVE REFERRED**  
*See Policy H-305.988*

RESOLVED, That our American Medical Association advocate that resident and fellow trainees should not be financially responsible for their training; and be it further

[**REFERRED**] RESOLVED, That our AMA 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.

**322. BOARD OF MEDICINE SANCTIONS AND FINES**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association 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.

**323. ENSURING EQUALITY IN LOAN REPAYMENT PROGRAMS FOR MARRIED COUPLES**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy H-305.928*

RESOLVED, That our American Medical Association oppose any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.

**324. PROPOSING CHANGES TO PUBLIC SERVICE LOAN FORGIVENESS**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-305.993*

RESOLVED, That our American Medical Association advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; and be it further

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; and be it further

RESOLVED, That our AMA 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.

**325. BROADEN CONFLICT OF INTEREST DISCLOSURE**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association 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.

**326. OBESITY EDUCATION IN MEDICAL SCHOOLS AND RESIDENCY PROGRAMS**  
**Introduced by American Association of Clinical Endocrinologists**

Resolution 326 was considered with Resolution 315. See Resolution [315](#).

RESOLVED, That our American Medical Association create a report on the current state of obesity education in medical schools; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA create a model curriculum regarding obesity for medical schools to ensure that all individuals receive the same standard of care, regardless of their weight.

**327. ACHIEVING TRANSPARENCY THROUGH GRADUATE  
MEDICAL EDUCATION FUNDING REFORM**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA support combining Indirect Graduate Medical Education into the Direct Graduate Medical Education payments into a single, transparent funding stream; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA support that the payment of Graduate Medical Education funding being 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.

**328. EVALUATION OF RESIDENT AND FELLOW COMPENSATION LEVELS**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA advocate that resident and fellow trainees should not be financially responsible for their training; and be it further

RESOLVED, That our AMA 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.

**329. PRINCIPLES OF GME FUNDING REFORM**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support 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; and be it further

RESOLVED, That our AMA support that the allocation of Graduate Medical Education funds within an institution should be transparent and accountable to all stakeholders; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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-payor system; and be it further

RESOLVED, That our AMA support additional federal funding for Graduate Medical Education that provides flexibility for innovation in training and education above and beyond current levels of funding.

**330. TELEMEDICINE IN GRADUATE MEDICAL EDUCATION**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee C](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association advocate for educating resident and fellow physicians during their training on the use of telehealth technology in their future practices; and be it further

RESOLVED, That our AMA 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.

**401. ERADICATING HOMELESSNESS**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-160.903*

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, which recognize the positive impact of stable and affordable housing coupled with social services; and be it further

RESOLVED, That our AMA support the appropriate organizations in developing an effective national plan to eradicate homelessness.

**402. LABELING AND RECOMMENDED PROTECTION FOR SUNGLASSES**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-440.933*

RESOLVED, That our American Medical Association recognize, based on current evidence, that sunglasses that protect against 100% of both UVA and UVB radiation are currently the safest choice for consumers; and be it further

RESOLVED, That our AMA recommend that manufacturers clearly label all sunglasses with the percentage of UVA and UVB radiation blocked so that consumers know the extent to which the glasses protect against both types of UV radiation.

**403. PROMOTING FOOD RECOVERY EFFORTS IN HOSPITALS**  
**Introduced by Medical Student Section**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY D-150.978 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support sustainability, better nutrition, and improved community health outcomes through hospital food recovery programs by encouraging state medical societies and physicians to collaborate with local hospitals and food recovery programs present in the community.

**404. ALTERING SCHOOL DAYS TO ALLEVIATE ADOLESCENT SLEEP DEPRIVATION**  
**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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.

**405. INCREASING THE CONSUMPTION OF HEALTHY FRESH FOODS IN FOOD DESERT COMMUNITIES USING MOBILE PRODUCE FOOD VENDOR PROGRAMS**  
**Introduced by Medical Student Section**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-150.937 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support expanding the use of current state and federal food assistance programs (e.g. Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children Fruit and Vegetable Cash Value Voucher; and the US Farm Bill) to include purchasing fruits and vegetables from licensed and/or certified healthy mobile produce vendors.

**406. INCREASING TOY GUN SAFETY**  
**Introduced by Minority Affairs Section**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**

*See Policy H-145.974*

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; and be it further

RESOLVED, That our AMA encourage parents to increase their awareness of toy gun ownership risks.

**407. ENCOURAGING PROTOCOLS TO ASSIST WITH THE MANAGEMENT OF PATIENTS WITH OBESITY DURING POSITIONING AND TRANSPORTATION**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy H-10.962*

RESOLVED, That our American Medical Association encourage health care professionals to learn about techniques and devices to prevent potential injury and to provide safe and effective care for patients with obesity.

**408. COMMUNITY-BASED FALLS PREVENTION PROGRAMS**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy H-25.988*

RESOLVED, That our American Medical Association work with relevant organizations to support community-based falls prevention programs.

**409. ADDRESSING IMMIGRANT HEALTH DISPARITIES**  
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-350.957*

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 and publicize medically accurate information 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 eliminate health disparities affecting immigrants, refugees or asylees.

**410. MENTAL HEALTH CRISIS INTERVENTIONS**  
**Introduced by California**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-345.975 AND H-345.995 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association continue to support jail diversion and community based treatment options for mental illness; and be it further

RESOLVED, That our AMA support implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the crisis intervention team model programs; and be it further

RESOLVED, That our AMA explore funding to encourage increased community and law enforcement participation in crisis intervention training programs.

**411. HOMELESS VETERANS**  
**Introduced by California**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-510.986 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED That our American Medical Association support federal, state, and local efforts to reduce homelessness among veterans and to improve their access to health care.

**412. REGULATION OF ELECTRONIC CIGARETTES**  
**Introduced by California**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: POLICIES H-495.972 AND H-495.987 AMENDED AND  
POLICY H-495.973 REAFFIRMED  
IN LIEU OF RESOLUTION 412**

Policy H-495.972 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.

Policy H-495.987 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.

**413. AIRCRAFT RESTRAINTS ON SMALL CHILDREN**  
**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: POLICY H-45.989 AMENDED  
IN LIEU OF RESOLUTION 413**

Policy H-45.989 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.

**414. HEADPHONE PUBLIC AWARENESS CAMPAIGN**  
**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: POLICY H-15.952 AMENDED  
IN LIEU OF RESOLUTION 414**

Policy H-15.952 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.

**415 INCREASING THE SMOKING AGE**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-510.986 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association reaffirm its existing policy supporting an increase in the legal age of sale of tobacco products in the United States from 18 to 21 years.

**416. PREVENTING ALLERGIC REACTIONS IN FOOD SERVICE ESTABLISHMENTS**  
**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**  
*See Policy D-440.932*

RESOLVED, That our American Medical Association pursue federal legislation 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.

**417. AUTO HEAT DEATHS**  
**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-15.949*

RESOLVED, That our American Medical Association support efforts to reduce deaths of children left in unattended vehicles.

**418. COUNTRY ROAD INTERSECTIONS**  
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-15.990 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association recognize the health risks, especially traumatic injuries, associated with dangerous roads and intersections and urge appropriate government entities to take appropriate action to reduce risk and increase safety.

**419. TAXATION OF TOBACCO PRODUCTS**  
**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: POLICIES H-495.972 AND H-495.987 AMENDED AND  
POLICY H-495.973 REAFFIRMED  
IN LIEU OF RESOLUTION 419**

Policy H-495.972 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.

Policy H-495.987 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.

**420. BANNING THE USE OF ARTIFICIAL TRANS FATS IN THE UNITED STATES**  
**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: POLICY H-150.941 AMENDED  
 IN LIEU OF RESOLUTION 420**

Policy H-150.941 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.

**421. RAISE MINIMUM LEGAL AGE TO PURCHASE TOBACCO PRODUCTS TO 21**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: POLICY H-495.986 AMENDED AND  
 POLICIES H-495.972 AND H-495.973 REAFFIRMED  
 IN LIEU OF RESOLUTIONS 421 AND 424**

Policy H-495.986 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. (2) ...

**422. FDA TOBACCO DEEMING RULE**  
**Introduced by American Thoracic Society**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-495.973, H-495.978 AND H-495.988 REAFFIRMED**  
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association reaffirm our strong policy supporting the Food and Drug Administration's (FDA) authority to regulate all tobacco products; and be it further

RESOLVED, That our AMA send a letter to the FDA and to the Administration urging swift adoption of a final rule deeming the Food and Drug Administration's authority over all tobacco products.

**423. SUPPORT OF PROTECTIVE HEADGEAR (HELMETS) IN THE**  
**SPORT OF GIRLS'/WOMEN'S LACROSSE**  
**Introduced by New York**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE**  
*See Policy H-470.955*

RESOLVED, That our American Medical Association support requiring approved protective headgear for all athletes participating in the sport of girls'/women's lacrosse.

**424. CHILD-PROOF PACKAGES FOR E-CIGARETTE LIQUID REFILLS**  
**Introduced by New York**

Resolution 424 considered with Resolution 421. See Resolution [421](#).

RESOLVED, That our American Medical Association support regulations and/or legislation to have the Food and Drug Administration require that liquid nicotine be only available in child-resistant packages; and be it further

RESOLVED, That our AMA work toward achieving that the sale of nicotine come with appropriate warnings of the dangers of nicotine and instructions on its safe storage; and be it further

RESOLVED, That our AMA work toward a prohibition in the United States on the sale and distribution of liquid nicotine to anyone under the age of 21.

**425. BAN ON POWDERED ALCOHOL DISTRIBUTION AND SALE**  
**Introduced by Maryland**

*Reference committee hearing: see report of [Reference Committee D](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association adopt policy urging the ban of the distribution and sale of powdered alcohol; and be it further

RESOLVED, That our AMA lobby Congress and the Administration to ban by law or regulation the distribution and sale of powdered alcohol in the US.

**501. ADDRESSING DRUG OVERDOSE AND PATIENT COMPLIANCE WITH  
TARGETED PHARMACEUTICAL PACKAGING EFFORTS**

**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-115.967*

RESOLVED, That our American Medical Association support research into, and development of, novel and affordable pharmaceutical packaging for dispensed medications, as well as abuse deterrent formulations in attempts to increase ease of use, improve patient adherence, and decrease the potential for misuse and abuse of controlled substances.

**502. TRAINING IN PRECONCEPTION COUNSELING AND LONG-ACTING  
REVERSIBLE CONTRACEPTIVE METHODS**

**Introduced by Medical Student Section**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS  
WITH CHANGE IN TITLE**

*See Policy H-75.987*

RESOLVED, That our AMA support the training of all primary care physicians 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.

**503. HEALTH EFFECTS OF REDUCED PASSENGER SPACE FOR LONG DISTANCE  
AND INTERNATIONAL TRAVEL**

**Introduced by International Medical Graduates Section**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: POLICIES H-45.979 AND D-45.998 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION 503**

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA reaffirm its existing policies regarding air passenger safety and also communicate those policies to the airline industry and the FAA.

**504. PHYSICIAN DETERMINATION FOR APPROPRIATE MEDICATION REFILLS**  
**Introduced by Virginia**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy D-120.942*

RESOLVED, 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.

**505. PRESCRIPTION PRODUCT LABELING**  
**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery,  
American College of Mohs Surgery and Society for Investigative Dermatology**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
**POLICY H-115.994 AMENDED**  
**POLICY H-120.988 REAFFIRMED**  
*See Policy TBD*

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.

Policy H-115.994 amended by addition and deletion to read as follows:

H-115.994 Prescription Product Labeling

The official labeling should not be regarded as ~~the sole 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 establish the parameters governing advertising or promotion of the drug product.

**506. REDUCTION OF CARBON DIOXIDE POLLUTION FROM ENERGY PRODUCTION**  
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: POLICIES H-135.949 AND D-135.972 AMENDED  
IN LIEU OF RESOLUTION 506**

Policy H-135.949 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.

Policy D-135.972 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.

#### **507. NEXT GENERATION INFECTIOUS DISEASES DIAGNOSTICS** **Introduced by Infectious Diseases Society of America**

*Reference committee hearing: see report of [Reference Committee E](#).*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy H-440.834*

RESOLVED, That our American Medical Association support strong federal efforts to stimulate early research and development of emerging rapid infectious disease (ID) diagnostic technologies through increased funding for appropriate agencies; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA support efforts to overcome reimbursement barriers to ensure coverage of the cost of emerging diagnostics.

#### **508. CHEMICALS USED DURING THE HYDRAULIC FRACTURING (FRACKING) PROCESS** **Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of [Reference Committee E](#).*

#### **HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 508 AND 510**

*See Policy H-135.931*

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.

**509. LONG-ACTING REVERSIBLE CONTRACEPTION AND TEEN PREGNANCY  
Introduced by California**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-75.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support approaches to preventing teen pregnancy that include and prioritize long-acting, reversible contraceptive (LARC) methods, such as the American Academy of Pediatrics' CHOICE Program.

**510. NATURAL GAS FRACKING: MONITORING TO PROTECT HUMAN HEALTH  
Introduced by Florida**

Resolution 510 considered with Resolution 508. See Resolution [508](#).

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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.

**511. HEPATITIS C TREATMENT  
Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: POLICY H-440.845 AMENDED  
IN LIEU OF RESOLUTION 511  
*See Policy TBD***

Policy H-440.845 amended in lieu of Resolution 511

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.

**512. OFF-LABEL USE OF HORMONE THERAPY**  
**Introduced by Women Physicians Section**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, 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.

**513. INCREASING AWARENESS OF NOOTROPIC USE**  
**Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED**

*See Policy D-100.969*

RESOLVED, That our American Medical Association recognize that nootropic use may be a potential health problem; and be it further

RESOLVED, That our AMA research the demand, use, and adverse effects of nootropics used individually and in combination.

**514. FUNDING THE BRAIN RESEARCH THROUGH ADVANCING INNOVATIVE**  
**NEUROTECHNOLOGIES (BRAIN) INITIATIVE**

**Introduced by American Academy of Neurology**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED**

*See Policy H-460.904*

RESOLVED, 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, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease.

**515. OPPOSE EPA SCIENTIFIC ADVISORY BOARD REFORM ACT**  
**Introduced by American Thoracic Society**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: FIRST RESOLVE ADOPTED**  
**SECOND, THIRD AND FOURTH RESOLVES REFERRED FOR DECISION**  
*See Policy H-460.900*

RESOLVED, That our American Medical Association reaffirm our strong support for the value of independent scientific advice provided by federal advisory panels; and be it further

[Referred] RESOLVED, That our AMA oppose legislation seeking to limit the role of scientists on EPA federal advisory panels and increase the role of industry representatives on such panels; and be it further

[Referred] RESOLVED, That our AMA oppose legislation seeking to add additional regulatory steps into the EPA federal advisory committee process; and be it further

[Referred] RESOLVED, That our AMA 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.

**516. OPPOSE SECRET SCIENCE REFORM ACT**  
**Introduced by American Thoracic Society**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: FIRST RESOLVE ADOPTED**  
**SECOND AND THIRD RESOLVES REFERRED FOR DECISION**  
*See Policy H-460.899*

RESOLVED, That our American Medical Association reaffirm our strong support for the value of peer review system in ensuring openness and fidelity in the scientific process; and be it further

[Referred] RESOLVED, That our AMA oppose legislation seeking to limit the science that EPA can use in rulemaking; and be it further

[Referred] RESOLVED, That our AMA send a letter to Congress expressing our opposition to legislation seeking to limit the science that EPA can use in rule making.

**517. ADDRESSING RECREATIONAL MISUSE AND DIVERSION OF CONTROLLED SUBSTANCES**  
**Introduced by New Jersey**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**  
*See Policy D-95.981*

RESOLVED, That our American Medical Association, in conjunction with other Federation members, 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.

**518. INCREASING ACCESS TO CARE FOR PATIENTS WITH OPIOID USE DISORDERS**  
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-95.979, H-95.990, H-120.960, H-185.974, D-120.953 AND D-180.998**  
**REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage primary care physicians (including psychiatrists) to voluntarily complete appropriate training which would best increase access to care for opioid use disorders, and which would include, but not be limited to:

- a) CME courses on screening, brief intervention, prescribing of medications for substance use disorders and referral for specialized care,
- b) CME courses on opioid use disorders and
- c) CME which meets the requirements for certification to become licensed to prescribe buprenorphine; and be it further

RESOLVED, That our AMA support policies and initiatives to provide adequate compensation for primary care physicians (including psychiatrists) for the treatment and counseling of patients with opioid use disorders; and be it further

RESOLVED, That our AMA support efforts to end the limitation of 100 patients per certified physician treating opioid dependence after the second year of treatment as currently mandated by the Drug Addiction Treatment Act.

**519. PROTECTING PUBLIC HEALTH FROM NATURAL GAS INFRASTRUCTURE**  
**Introduced by New York**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-135.930*

RESOLVED, That our American Medical Association recognize the potential impact on human health associated with natural gas infrastructure; and be it further

RESOLVED, That our AMA support legislation that would require a comprehensive Health Impact Assessment regarding the health risks that may be associated with natural gas pipelines.

**520. BAN ROUTINE USE OF ANTIBIOTICS IN ANIMAL FEED**  
**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-440.846 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for a total ban of antibiotics in animal feed to reduce the incidence of spillage to natural systems and to reduce the emergence of multi-drug resistant organisms that are difficult to treat.

**521. PROMOTING GOOD FOMITE STEWARDSHIP IN CLINICAL SETTINGS**  
**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-440.856 AND H-440.908 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association educate physicians regarding the best practices for cleaning portable electronic devices and other fomites.

**522. MEDICATION EXPIRATION DATES**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED**  
*See Policy H-115.983*

RESOLVED, That our American Medical Association amend Policy H-115.983 by addition and deletion 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.

**523. EVALUATION OF CANADIAN UNDERGROUND NUCLEAR WASTE REPOSITORY**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy D-135.971*

RESOLVED, That our American Medical Association, along with state and county medical societies, urge 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.

**524. MEDICAL CONSEQUENCES OF NUCLEAR WAR  
Introduced by Maryland**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED  
IN LIEU OF RESOLUTION 525  
POLICIES H-520.988, H-520.994, H-520.995, H-520.996 AND  
H-520.999 REAFFIRMED**  
*See Policy D-440.972*

RESOLVED, That our American Medical Association urge the US 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 and H-520.999 be reaffirmed.

**525. MEDICAL CONSEQUENCES OF NUCLEAR WAR AND THE NEED  
TO ABOLISH NUCLEAR WEAPONS  
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont**

Resolution 525 considered with Resolution 524. Resolution 524.

RESOLVED, That our American Medical Association:

- 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 be it further

RESOLVED, That our AMA study and report back on the issue of the public health dangers of limited as well as major nuclear war.

**526. RECYCLING PHARMACEUTICAL PROFITS TO NIH FUNDING  
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont**

*Reference committee hearing: see report of [Reference Committee E](#).*

**HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, 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.

**601. ENGAGING AND EMPOWERING OUR MEMBERS****Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association shall: 1) define a process and workflow to allow all individual AMA members in good standing to introduce resolutions directly into our HOD proceedings without changing the rights and privileges of current members of the HOD; 2) include (in that process) means to filter out inappropriate and duplicative resolutions; 3) provide for education and explanation to all AMA members who introduce resolutions as individuals; and 4) bring this proposed process and workflow for consideration by the House of Delegates to the Interim Meeting in 2015; and be it further

RESOLVED, That our bylaws shall be revised to allow all individual AMA members in good standing to introduce resolutions directly into the HOD proceedings.

**602. DONATING REIMBURSEMENTS TO THE AMERICAN MEDICAL ASSOCIATION FOUNDATION****Introduced by Minority Affairs Section**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association explore a mechanism to make a donation from its non-employee travel reimbursement worksheet to allow members of the Board of Trustees, council, 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, when specified, another AMA Foundation program benefitting medical students.

**603. TRANSPARENCY OF ORIGINS IN THE CATALOGUE OF AMA POLICIES****Introduced by American Medical Group Association**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That, beginning with new HOD policy passed at the 2015 Annual Meeting, the listing of these new or reaffirmed AMA policies will include naming the primary sponsoring organization(s) of the original resolution that led to the listed policy.

**604. A NEW DEFINITION OF “WOMEN’S HEALTH”****Introduced by Women Physicians Section**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That future discussion within our American Medical Association of topics labeled as “women’s health” reflect this more accurate and inclusive definition; i.e., the term “women’s health” refers to 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; and be it further

RESOLVED, That our AMA encourage members to incorporate evidence-based information regarding the impact of sex and gender into their daily practices.

#### **605. ORAL HEALTH**

**Introduced by American Academy of Family Physicians; American Association of Public Health Physicians;  
American College of Preventive Medicine and American Academy of Pediatrics**

*Reference committee hearing: see report of [Reference Committee F](#).*

#### **HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association endorse Smiles for Life: A National Oral Health Curriculum.

#### **606. INFORMATIONAL REPORTS SUBMITTED TO THE HOD**

**Introduced by Alabama**

*Reference committee hearing: see report of [Reference Committee F](#).*

#### **HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association take the necessary steps to see that informational reports submitted to the House of Delegates may be acted upon in the same fashion as regular reports and resolutions; and be it further

RESOLVED, That any report or resolution in the future that is not accepted and is still somehow published in our proceedings have the words “Not Accepted by the House of Delegates” or something similar printed in large bold face letters over the report or resolution so that there is no question to others who are using our website as to what our policy really is.

#### **607. PREVENTING VIOLENT ACTS AGAINST HEALTH CARE PROVIDERS**

**Introduced by American College of Cardiology, Heart Rhythm Society,  
American Society for Echocardiography and Society for Cardiovascular Angiography and Interventions**

*Reference committee hearing: see report of [Reference Committee F](#).*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS**

*See Policy D-515.983*

RESOLVED, that our American Medical Association work with other appropriate organizations 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.

#### **608. FIDUCIARY RESPONSIBILITY AND THE AMA INTERIM MEETING**

**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee F](#).*

#### **HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association, to be prudent to all its members and components, exercise absolute fiduciary responsibility by: (1) immediately discontinuing the AMA Interim Meeting of the House of Delegates outside of the contiguous 48 states to meet this achievement, and (2) immediately cancelling any such meetings and finding appropriate alternatives—knowing that any penalties of such action will be much less than

spending the monies to hold the meeting at such a location. Achieving such fiduciary responsibility will engender tremendous good will among its membership and can serve as an example to aid in new member acquisition.

**609. PHYSICIAN ENTREPRENEUR ACADEMY**  
**Introduced by Michigan**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: ADOPTED**

*See Policy D-630.969*

RESOLVED, That our American Medical Association study the possibility of developing an entrepreneur and business training academy to offer online and onsite training and skill development for AMA members.

**610. REQUIREMENT THAT THERE BE NO DIMINUTION IN PHYSICIAN  
REPRESENTATION ON THE JOINT COMMISSION**  
**Introduced by New Jersey**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association and its appointees to The Joint Commission take whatever steps necessary to ensure that physician representation is maintained as a majority of the commissioners on The Joint Commission.

**611. REPORT TO AMERICAN MEDICAL ASSOCIATION BY THE AMA APPOINTEES  
TO THE JOINT COMMISSION**  
**Introduced by New Jersey**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association appointed members of the Joint Commission file a written report on issues pertaining to the delivery of quality healthcare and patient safety on at least an annual basis with the AMA Board of Trustees; and be it further

RESOLVED, That our AMA Board of Trustees provide the report written by its appointees to the Joint Commission to the House of Delegates for its consideration.

**612. INCREASING COLLABORATION BETWEEN PHYSICIANS AND THE PUBLIC  
TO ADDRESS PROBLEMS IN HEALTH CARE DELIVERY**  
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of [Reference Committee F](#).*

**HOUSE ACTION: ADOPTED**

*See Policy H-160.904*

RESOLVED, That our American Medical Association consider methods to further engage the public in support of AMA measures designed to improve the delivery of quality medical care; and be it further

RESOLVED, That our AMA consider the creation of a Citizens Advisory Group, consisting of patients, lay caregivers, and other non-physician members, to assist the Board of Trustees and the House of Delegates, with goals including but not limited to:

1. Attaining full understanding of the problems confounding the delivery of quality medical care,
2. Providing the Board of Trustees and House of Delegates with commentary regarding these pertinent issues,
3. Articulating these concerns and issues to the public at large, and
4. Encouraging the public to communicate their concerns and recommendations to their elected officials in a timely fashion.

#### **701. PAYERS MISUSING APPROPRIATE USE CRITERIA**

**Introduced by Society for Cardiovascular Angiography and Interventions, American College of Cardiology, American Society for Echocardiography, Heart Rhythm Society, American Association of Neurological Surgeons and Congress of Neurological Surgeons**

*Considered on reaffirmation calendar.*

#### **HOUSE ACTION: POLICIES H-320.946, D-385.974 AND D-410.995 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support the intended use of AUCs as clinical resources for qualified medical professionals and not as instruments to govern payment, test substitution or other economic-related decisions; and be it further

RESOLVED, That our AMA work with specialty societies and payers to ensure that AUCs are used for their intended purposes by qualified medical professionals and not by third parties as instruments to oppose or override individual patient centered clinical decision making.

#### **702. ACCESS TO IN-OFFICE ADMINISTERED DRUGS**

**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery, American College of Mohs Surgery and Society for Investigative Dermatology**

*Reference committee hearing: see report of [Reference Committee G](#).*

#### **HOUSE ACTION: ADOPTED AS FOLLOWS** *See Policy H-330.884*

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

RESOLVED, That our AMA work with the Center for Medicare & Medicaid Services, 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; and be it further

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.

**703. PREVENTION OF PHYSICIAN CREDENTIALING ABUSE IN  
EMPLOYED PHYSICIAN SETTINGS  
Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-180.956 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support or cause to be introduced legislation that would require large corporate medical organizations and insurance companies to:

- a) Review a physician's application and credentials;
- b) Make a determination; and
- c) Notify physicians and relevant parties within 30 to 60 days.

**704. VIRTUAL CREDIT CARD PAYMENTS  
Introduced by Illinois**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**

*See Policy H-190.955*

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.

**705. PRE-AUTHORIZATION SIMPLIFICATION AND STANDARDIZATION  
Introduced by Washington**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That these best practices recommendations should include timely and binding preauthorization procedures for expensive procedures when requested by a physician or a patient; and be it further

RESOLVED, That our AMA advocate that NCQA, URAC, and ERISA adopt these recommendations; and be it further

RESOLVED, 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.

**706. THE ELECTRONIC DISCONTINUATION OF MEDICATIONS**  
**Introduced by North Carolina**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-120.939 AND D-120.965 REAFFIRMED  
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support the development of a standardized, electronic method for the communication of allergies to medications and the discontinuation of medications between the physician and the patient's pharmacy to improve medication reconciliation and patient safety; and be it further

RESOLVED, That our AMA work with the American Pharmacists Association and other appropriate interested parties to develop a method to allow physicians and other healthcare providers the ability to discontinue medications electronically, as well as report allergies to medications electronically or through e-prescribing, for the improved safety of patients.

**707. PAIN AS THE FIFTH VITAL SIGN**  
**Introduced by New York**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That the American Medical Association 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 patients 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; and be it further

RESOLVED, That the AMA recommend that "pain as the fifth vital sign" be removed from the clinical practice environment; and be it further

RESOLVED, That our AMA encourage The Joint Commission remove "pain as the fifth vital sign" from its standards.

**708. "INCIDENT TO" BILLING AND NPI NUMBERS ON CLAIMS**  
**Introduced by Iowa**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, 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.

**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**  
Introduced by New Jersey

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED  
POLICIES H-510.986 and D-510.994 REAFFIRMED**  
*See Policy D-510.991*

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.

**710. NOTIFICATION TO PHYSICIANS REGARDING COBRA GRACE PERIOD**  
Introduced by Texas

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: ADOPTED AS FOLLOWS**  
*See Policy H-185.930*

RESOLVED, That our American Medical Association 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.

**711. PROTECTING AGAINST FORCED NETWORK EXCLUSIVITY OF SPECIALIST PHYSICIANS**  
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED  
POLICIES H-160.915 AND H-285.989 REAFFIRMED**  
*See Policy H-285.906*

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.

**712. INCREASING PRIOR AUTHORIZATION REQUIREMENTS**  
Introduced by New Mexico

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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 such as:

- Alternative models of quality-based and shared-risk reimbursement that reduce or obviate the need for prior authorization;
- Reimbursement of physicians for time and resources spent on compliance with prior authorization requirements, taking into consideration recent legal precedent;
- Whether new CPT codes would need to be developed in order for physicians to bill for reimbursement for time and resources spent on compliance with prior authorization requirements;
- Regulations or legislation that prohibit 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;
- Standardization of formulary formats, including new requirements that formularies be importable into ONC certified electronic health records;
- Requirements that insurance company practices regarding medication substitution meet accepted standards developed by medical specialty societies for patient safety, efficacy and equivalence;
- Requirements that insurance companies not use lack of an FDA indication or designation of a medication as a “high risk” as justification for denial, overriding clinical judgment and accepted standards of care; and be it further

RESOLVED, That our AMA consider the inclusion of prior authorization requirements in the AMA’s Professional Satisfaction and Practice Sustainability strategic focus; and be it further

RESOLVED, That our AMA consider 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.

**713. INCLUDE TELEMEDICINE IN THE DEFINITION OF DIRECT SUPERVISION**  
**Introduced by New Mexico**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association 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.

**714. HOSPITAL ADMISSION PROCESSES AND COMMUNICATION BETWEEN**  
**PATIENTS’ PRIMARY CARE AND HOSPITAL-BASED PHYSICIANS**  
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: REFERRED**

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 a primary care physician; and (2) 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.

**715. MEDICAL SERVICES – BILLING AND COLLECTING**  
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED**

*See Policies H-185.944, H-190.959 and D-185.999*

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.

**716. PRINCIPLES FOR MEASURING AND REWARDING PHYSICIAN PERFORMANCE**  
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of [Reference Committee G](#).*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association study and consider adopting as AMA policy the following proposed “Principles for Measuring and Rewarding Physician Performance,” with report back at the 2015 Interim Meeting:

Principles for Measuring and Rewarding Physician Performance

Increasingly, physicians are being judged by systematic measurement and reporting of their performance on selected quality indicators, by patient experiences with the care received, and by assessment of the appropriateness and cost-effectiveness of care. Quality improvement programs that have these goals should:

- use objective, well-validated, and clinically important measures of quality;
- ensure accurate and timely assessment of these measures;
- include physicians in both primary care and medical specialties;
- provide for timely review of reports by involved physicians prior to public release;
- ensure that reports released to the public can be easily and accurately interpreted;
- make appropriate use of risk-adjustment and statistical methods when reports aim to compare performance among clinical practices or hospitals or make clear notation that population differences make direct comparisons difficult or impossible;
- use appropriate incentives to reward superior performance and stimulate continuous improvement in the quality of care being provided;
- promote and facilitate the adoption of information technology (IT) tools including electronic health records (EHRs).

A. Goals of Performance Measurement

- The primary goal of performance measurement is to improve the quality of health care by providing physicians with meaningful information on their clinical performances. Hence, success should be measured by evidence of improvement over time in the structures, processes, and outcomes of care.
- Other important goals are to ensure physician accountability to the needs of health care consumers and accrediting and regulatory entities.

- Physician leadership is essential in developing and implementing performance measurement activities to ensure their clinical relevance and to help inform patients and the community about aspects of health care that are particularly important to physicians.
  - Performance measurement must address local, as well as regional and national, priorities if local needs are to be satisfied and active physician participation is to be assured.
- B. General Principles of Physician Performance Measurement
- Performance measures should be clinically relevant to the individual physician or group practice being evaluated. Markers of importance include high prevalence; significant impacts on mortality, morbidity, or costs; and high degrees of practice variation where variations have well-documented relationships to health outcomes.
  - Physicians should be evaluated only with respect to patients and clinical services for whom/which they are directly responsible. Where responsibility for care is shared, the team, group practice, or hospital service should be the unit of evaluation. When attribution is uncertain, evaluation should be at the higher level of aggregation.
  - Performance measures should, to the maximum extent possible, be firmly grounded in scientific evidence. Where the science base is inadequate, professional consensus may be substituted. In either case, sources of support for the measure and their validity should be fully documented and readily accessible.
  - The process for selecting the range of performance measures to be included should take into account the perspectives of all involved parties including physicians, patients, health plans, provider organizations, employers, payers, and regulatory agencies.
  - Quality measures must be clinically important, prospectively defined, and designed for objective and accurate measurement. They should be evidence based and directed at medical specialists as well as primary care physicians. Measures aimed at health care outcomes are preferred. Measures should adjust for case mix, distinguish between ordering and referring physicians, and other factors such as race and ethnicity if empirical evidence suggests a correlation (AMA, NQF). Measures aimed at processes of care are also important if they are closely linked to improved outcomes.
  - Many quality measures used today, including Health Plan Employer Data and Information Set measures, are of marginal clinical importance. Such data should not be used in the physician peer-review process. Physician peer review should be conducted in accordance with the AMA's Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA policy H-375.965).
  - Technical barriers to accurate and timely measurement of quality need to be confronted. As sources of data, claims data have the advantages of being readily available, relatively low in cost, and inclusive of important parameters such as diagnostic and procedure codes. Shortcomings include delays in obtaining access to the data, inaccuracies, and inadequate information on the clinical needs of patients and socioeconomic indicators that may affect outcomes. Standardization of EHRs is central to improved measurement, as interoperability will allow for coordinated and complete data collection. The development of such systems should be a high priority.
  - The costs of quality measurement can be considerable. Costs should be justified by tangible evidence of resulting improvements in health care quality and/or savings in the costs of health care. Measures of cost should include the added clerical burdens on physician practices or managed care organizations.
  - Physicians should be intimately involved in all aspects of quality measurement in: developing quality measures, implementing and monitoring quality measurement, and reporting results to practices and the public. To these ends, physicians should work in close collaboration with payers, quality measurement organizations, and regulators.
- C. Development of a Performance Measurement Program
- Development of effective performance measurement programs requires close collaboration among physicians, their health care organizations, payers, and regulatory agencies.
  - Expected benefits of performance measurement should be weighed against the burden and costs for the program as a whole, and for each performance measure. The value of performance measurement will be increased by the use of standardized measures and methods, avoidance of duplication of effort, and steps to ensure the accuracy and usefulness of results.
  - Ongoing performance measurement activities should receive regular external evaluations. These evaluations should focus on the choice of performance measures, data collection and analysis strategies, the accuracy of the results obtained, and the appropriateness of interpretation of results.

- Organizations that conduct performance measurement (provider organizations and vendors) should disclose fully their performance measurement objectives, policies, and methods, and make these readily accessible to both the physicians being assessed and the public.
- The burden and costs of performance measurement should be fairly allocated among those who will potentially benefit including physicians, patients, health plans, payers, employers, and regulatory agencies.

#### 1. *Characteristics of Performance Measures*

- Measures should be based on data available to the clinician in the real-time clinical setting and should have clear implications for actions to improve the quality of care.
- Measures should be standardized and capable of systematic and objective measurement. Relevant data sources must be available, accurate, and reasonably complete.
- To the extent possible, measures should rely on data that are routinely collected during usual patient care.
- The burden of data collection for a measure should be reasonable.
- Measures should be updated at regular intervals to reflect changes in medical knowledge or the norms of practice.
- Measures of clinical outcomes should be risk-adjusted so that results appropriately reflect patients' severity of illness at the time of presentation or time of clinical action. Methods used for risk-adjustment should be accurate at all levels of severity of the illness.
- Measures and associated analytic methods should be clearly defined and fully disclosed to necessary parties. Measures based on un-disclosed algorithms or software are not acceptable.

#### 2. *Types of Performance Measures*

- Clinical outcome measures should be clearly related to processes of care that are under the control of the physician or group practice, and can be modified to affect the outcome.
- Process measures should be clearly linked by scientific evidence to direct effects on patient outcomes. They usually relate to diagnostic and treatment decisions but may also examine access to care or compliance with care regimens.
- Patient perceptions of and satisfaction with the quality of services are important. Patients should have input into the selection of these measures.
- Patients are often the best witnesses to assess the outcomes that they experience.
- Resource use and cost measures should be supported by evidence that patient care will not be adversely affected and expectations for benchmarks should be appropriate. When efficiency measures are used, quality measures should be used in conjunction with such measures to ensure there is appropriate utilization. Decisions on the use of such measures should include individuals with no direct financial stake in the care being evaluated.
- The primary purpose of performance measurement related to resource use and costs should be to raise awareness and inform quality improvement activities. Results should not be used for punitive purposes except in cases of flagrant overuse or clear waste.

#### 3. *Data Sources*

- Each data source should meet explicit standards of accuracy and completeness if valid comparisons are to be made among physicians or practices.
- The data source should be appropriate to the performance measure being examined.
- The data source should be readily available in all practices or health plans being compared.

#### 4. *Data Collection*

- Data collection protocols should be explicit, as objective as possible, and limited to essential items of data.
- Data collection from medical records or by survey should be performed by persons skilled in the methodology. Ideally, these individuals should be selected and reimbursed in a manner that will optimize objectivity and minimize bias.

#### 5. *Data Analysis*

- The level of analysis (individual physician, group practice, or health plan) should be appropriate to the ability of data to support meaningful analyses and the intended use of the report. Sample sizes of

events or cases that are too small to support analyses at the level of the individual physician may be useful for internal quality improvement but should not be released to the public.

- Analyses should be planned and conducted by individuals who are skilled in appropriate analytic techniques.
- Analytic techniques should be appropriate to the objectives of the analysis and the database.
- Reports should emphasize important differences between the entities being compared or time trends in performance, and include clear statements about the statistical significance and clinical importance of results.
- Reports that are to be released to the public should be based on adequate sample sizes and accurate data, and meet high standards of statistical validity. Independent external audits should be performed prior to release.
- Reports that are for internal discussion/use in quality improvement activities can be based on smaller sample sizes and may not require formal statistical analysis.
- Methods of analyses should be described in sufficient detail that results can be easily understood and, if necessary, reproduced.

#### 6. Risk-Adjustment

- Adequate risk-adjustment is essential to achieving valid comparisons among physicians, practices, or health plans on clinical outcomes and the appropriateness of decisions to perform surgical or diagnostic procedures.
- Simple adjustment for selected patient characteristics such as age, gender, and risk factors for the disease will be sufficient for certain process measures (e.g., mammographic screening for breast cancer).
- Risk-adjustment models should be carefully tested before they are used and should have demonstrated good calibration between predicted and actual outcomes at all levels of severity of illness. Generic risk-adjustment models can be used if they have been demonstrated to be valid for the particular condition and the particular type of clinical setting.
- The risk-adjustment methodology should be well-documented and open to inspection, preferably published in the peer-reviewed medical literature.

#### D. Distribution and Use of Performance Reports

- Physicians and physician groups being assessed should be the first to receive all reports that measure their performance. They should be given an opportunity to review and comment on reports prior to external release. In particular, physician “outliers” on a measure should be contacted to detect any unusual circumstances that explain the result. Documented errors should be corrected, and substantive comments or explanations should be appended.
- External distribution of physician performance results should be governed by the necessary parties as defined by the responsibilities of the entity and the content of the report. Criteria for external distribution, including rules governing confidentiality of content, should be explicitly stated and agreed to by all involved parties. For example, the public should receive reports that will help them select a physician, health plan, or hospital. Regulatory agencies should only receive information specified in their credentialing standards.
- Organizations that use physician performance reports should publicly disclose the types of information they need and how this information will be used to improve the quality of health care.
- Reports intended for public release should meet higher standards of accuracy, reliability, and statistical validity than those intended for internal discussion/use only. Reports should not be released when there are too few cases to support a meaningful analysis. Appropriate risk adjustment of results is essential. Reports intended for public release should be audited by an independent entity prior to their release.
- All reports, whether for internal or external use, should be clear and unambiguous and accompanied by materials that facilitate proper interpretation. Reports should be protected from discovery during legal proceedings.
- Performance reports used for internal quality improvement should remain confidential between the physician or physician group being measured and their immediate supervisors. Such reports should be protected from disclosure by peer review regulations, whenever possible.
- Reports keyed to sentinel events should be used only for internal quality improvement unless statistically valid patterns of performance can be documented.

- Patient-specific data may, where necessary, be released to the patient’s physician for use in internal quality improvement activities. Broader release of patient-specific data, however, should require explicit permission of the patient.
- E. Public Reporting of Physician Performance
- The public expects and deserves valid reports on the performance of all health care providers: medical practices, managed care organizations, hospitals, nursing homes, and other services.
  - Reports for public release must meet high standards for accuracy and statistical validity. Reports should not be released when there are too few cases to support a meaningful analysis. They should receive timely review by involved practices prior to release, and should be corrected for discovered errors or risks of misinterpretation. Particular attention should be given to ensure that physicians are held accountable only for care for which they are, in fact, responsible.
  - Reports that compare performance of physicians or practices to each other or to benchmarks must avoid using arbitrary cutpoints that designate practices as being “superior,” “above average,” “average,” or the like. Instead, performance should be rank-ordered according to the quality measure under consideration. Ranking should be based on clinically important and statistically significant differences.
  - Reports must pay careful attention to differences in sociodemographic and socioeconomic classes and cultural divides that may affect patient attitudes toward health care and adherence to recommendations of their physicians.
- F. Frequency of Performance Reports
- The frequency of reports depends on the intended purpose. If the goal is to achieve behavior change and quality improvement, frequent reinforcement by quarterly reports may be required. Annual reports are usually sufficient for comparisons among health plans or to satisfy accrediting agencies.
  - The burden of data collection and other costs of performance measurement will be limiting factors both for the selection of performance measures and the frequency of reports.
- G. Assessing the Quality of Patient-Physician Relationships
- Quality-measurement programs should be directed at supporting and improving patient-physician relationships. To these ends, they must reflect the vital importance of sound medical judgments as well as adherence to defined guidelines.
  - Programs should protect and improve access to high-quality health care for all patients. Program developers should be especially sensitive to minimizing barriers to access among patients who are disadvantaged by reason of ethnic, cultural, and socioeconomic barriers, or who have especially complex medical conditions, and should take positive steps to improve access to care for such patients.
  - Programs should aim to achieve equity in quality assessment for patients and their physicians, regardless of the setting in which care is delivered or the location of the population served (for example, inner city or rural areas). This challenge will be particularly difficult in practice settings that lack the needed infrastructure, including EHRs.
  - Programs should be “risk-adjusted” to reflect the important effects of patient non-adherence on performance outcomes. This is especially important when patient adherence is not reasonably under the control of the physician.
- Paying for Performance (P4P)
- Criteria, methodology, and background data for P4P on measures of quality and cost should be transparent to all involved. Practices involved with these incentives should have an opportunity to review their data and, preferably, begin improvement prior to the implementation of the incentives.
  - Monitor evidence on pay for performance and its effect on improving quality indicators in diverse practice settings.
  - Funding of P4P initiatives should come from additional resources. Financial incentives should not come from a redistribution of current physician and other health care provider reimbursement.
  - Requirements to achieve P4P goals should be made known to physicians in a timeframe that will allow them to safely alter the care they deliver in order to meet the goals.
  - Incentives should seek to move practices to the “next level” in terms of acquiring essential structural components (for example tracking systems or EHRs) that will improve processes or outcomes of care.

- P4P pilots should use incentives of sufficient magnitude to influence physician behaviors. Results should be carefully monitored to ensure that the intended objectives are met and that unexpected detrimental effects have not been introduced.
- P4P incentives should be aligned and standardized across payers, physician practices, and hospitals.
- Pay-for-performance statistics shall be applied only to those patients to whom the peer-reviewed medical evidence is applicable, including such criteria as: demographic characteristics, clinical characteristics, clinical significance, and life expectancy.