

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

**68th INTERIM MEETING
DALLAS, TEXAS
November 8–10, 2014**

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 68th Interim Meeting at 2 p.m. on Saturday, Nov. 8, in the Trinity Ballroom of the Hilton Anatole Hotel in Dallas, Texas, Andrew W. Gurman, MD, Speaker of the House of Delegates, presiding. The Sunday, Nov. 9, and Monday, Nov. 10 sessions also convened in the Trinity Ballroom. The meeting adjourned Monday afternoon.

INVOCATION: The following invocation was delivered by Reverend Katie Alexander, an ordained minister in the Christian Church, Disciples of Christ:

Grace to you, and peace, on this beautiful afternoon! I invite you to open your hearts in recognition of the many pathways through which we each find meaning and purpose:

Sacred source of life, infinite wind of wisdom, eternal hope of the world, we seek your holy presence in this gathering, and we are grateful for all in attendance and as well as those present with us in spirit.

Gracious One, we thank you for our individual gifts, but, even more, for our shared ministries of wellness. May this time together renew our calling to heal the world one heart at a time.

For in the midst of beauty and joy, so many are broken in body and spirit.

Open our minds to embrace new wisdom and truth; touch our hearts with compassion as we care for those who suffer; grant us patience and grace to see our patients who look to us for healing through your universal vision of love; use our hands to touch others with gentility; temper our words to offer comfort with even the most difficult news.

Empower us to live what we believe and inspire us to light candles of healing in the darkest corners of humanity. When our time today concludes, challenge each one of us to go forth to be a blessing of hope.

Amen

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Craig A. Backs, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, Nov. 8, 443 out of 527 delegates (84.11%) had been accredited, thus constituting a quorum; on Sunday, Nov. 9, 467 delegates (88.6%) were present; and on Monday, Nov. 10, 493 (93.5%) were present.

RULES REPORT – Saturday, November 8

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials recommends that:

1. House Security
Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly badged will be permitted to attend.

2. Credentials

The registration record of the Committee on Rules and Credentials shall constitute the official roll call at each meeting of the House.

3. Order of Business

The order of business as published in the Handbook shall be the official order of business for all sessions of the House of Delegates. This may be varied by the Speaker if, in his judgment, it will expedite the business of the House, subject to any objection sustained by the House.

4. Privilege of the Floor

The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.

5. Procedures of the House of Delegates

The November 2014 edition of the "House of Delegates Reference Manual: Procedures, Policies and Practices" shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates

6. Limitation on Debate

There will be a 3-minute limitation on debate per presentation subject to waiver by the Speaker for just cause.

7. Conflict of Interest

Members of the House of Delegates who have a substantial financial interest in a commercial enterprise, which interest will be materially affected by a matter before the House of Delegates, must publicly disclose that interest before testifying at a reference committee on the matter or speaking on the floor of the House of Delegates on the matter.

8. Conduct of Business by the House of Delegates

Each member of the House of Delegates, and the AMA Officers and Board of Trustees resolutely affirm a commitment to be courteous, respectful and collegial in the conduct of House of Delegate actions, characteristics which should exemplify the members of our respected and learned profession.

SUPPLEMENTARY REPORT – Sunday, November 9

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS

**LATE RESOLUTIONS 1001 (230), 1002 (936), 1003 (229) AND 1004 (827) ACCEPTED
AND ASSIGNED TO REFERENCE COMMITTEES AS INDICATED**

**EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 5, 203, 603, 802,
806, 816, 823, 905, 913 and 921**

(1) LATE RESOLUTIONS

The Committee on Rules and Credentials met Saturday, Nov. 8, 2014 to discuss Late Resolutions 1001–1004. Sponsors of Late Resolutions are informed of the time the Committee on Rules and Credentials meets to consider Late Resolutions, 8:30 a.m. on Saturday, and are given the opportunity to present for the Committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting. Sponsors of Late Resolutions 1001–1004 appeared to discuss their resolutions.

Accepted:

Late 1001 AMA Support of the Preventive Health Savings Act

Late 1002 Evidence-Based Policy for Health Care Workers Returning From West Africa

Late 1003 Preventing Drug Manufacturers from Restricting their Distribution Networks

Late 1004 Care Coordination

(2) REAFFIRMATION RESOLUTIONS

The Speakers asked the Committee on Rules and Credentials to review the recommendations for placing resolutions introduced at this meeting of the House of Delegates on the Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed remain active policies within the AMA policy database and therefore are part of the body of policy that can be used in setting the AMA's agenda. It also resets the "sunset clock," so that such policies will remain viable for ten years from the date of reaffirmation. The Committee recommends that current policy be reaffirmed in lieu of the following resolutions (current policy and AMA activities are listed in the Appendix to this report):

1. Resolution 5 - Opt-Out Organ Donation
2. Resolution 203 - Inclusion of Preventive Medicine Physicians in the National Health Service Corps Loan Repayment Program
3. Resolution 603 - Critical Congenital Heart Disease Screening Procedure Code
4. Resolution 802 - Advocating for Research on Physician Initiated Conversations About Treatment Cost
5. Resolution 806 - International In-Flight Medical Emergency Center
6. Resolution 816 - Burdensome Impact of Medicare's Face-to-Face Form Requirements
7. Resolution 823 - Medicare Coverage of Vaccines During Office Visits
8. Resolution 905 - Increasing Healthy Food Choices Among Families Supported by the Supplemental Nutrition Assistance Program
9. Resolution 913 - Dietary Supplement Dangers
10. Resolution 921 - A Tobacco Free Military

APPENDIX

- Resolution 5 Opt-Out Organ Donation
 - H-370.966 Organ Donor Recruitment
 - D-370.985 Organ Donation
- Resolution 203 Inclusion of Preventive Medicine Physicians in the National Health Service Corps Loan Repayment Program
 - D-305.974 Funding for Preventive Medicine Residencies
 - D-305.975 Long-Term Solutions to Medical Student Debt
 - D-200.978 Addressing the Shortage of Child and Adolescent Psychiatrists
 - D-305.982 Long Term Solutions to Medical Student Debt
- Resolution 603 Critical Congenital Heart Disease Screening Procedure Code
 - H-70.919 Use of CPT Editorial Panel Process
- Resolution 802 Advocating for Research on Physician Initiated Conversations About Treatment Cost
 - H-373.998 Patient Information and Choice
 - H-450.938 Value-Based Decision-Making in the Health Care System
 - H-373.997 Shared Decision-Making
 - In addition, per Policy D-155.989, Putting Price Transparency Into Practice, the Council on Medical Service will be developing a report for the 2015 Annual meeting that examines mechanisms to support and promote price transparency for physicians and patients.
- Resolution 806 International In-Flight Medical Emergency Center
 - H-45.979 Air Travel Safety
 - H-45.978 In-flight Medical Emergencies
 - In addition, at least two major in-flight medical emergency centers are in operation. MedAire, Inc, is affiliated with the Aerospace Medical Association and the Federal Aviation Administration. The University of Pittsburgh Medical Center's Department of Emergency Medicine operates STAT-MD Commercial Airline Consultation Services.

- Resolution 816 Burdensome Impact of Medicare's Face-to-Face Form Requirements
 - D-330.909 Study the Costs of Administrative and Regulatory Burdens
- Resolution 823 Medicare Coverage of Vaccines During Office Visits
 - H-440.875 Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines
 - H-440.860 Financing of Adult Vaccines: Recommendations for Action
- Resolution 905 Increasing Healthy Food Choices Among Families Supported by the Supplemental Nutrition Assistance Program
 - H-150.937 Improvements to Supplemental Nutrition Programs
- Resolution 913 Dietary Supplement Dangers
 - H-150.954 Dietary Supplements and Herbal Remedies
- Resolution 921 A Tobacco Free Military
 - H-490.913 Smoke-Free Environments and Workplaces
 - H-495.986 Tobacco Product Sales and Distribution

CLOSING REPORT – Monday, November 10

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Gurman, and the Vice Speaker, Doctor Bailey, for the outstanding manner in which they have assisted our deliberations by their fair and impartial conduct of the House of Delegates and to commend the members of the House for their cooperation in expediting the business before us.

Your Committee wishes at this time to offer the following Resolution:

Whereas, The Interim Meeting of the House of Delegates of the American Medical Association has been convened in Dallas, Texas, during the period of November 8-10, 2014; and

Whereas, This Interim Meeting of the House of Delegates has been most profitable and enjoyable from the viewpoint of policy deliberations and fellowship; and

Whereas, The City of Dallas has extended to the members attending this meeting the utmost hospitality and friendliness; therefore be it

RESOLVED, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of the Hilton Anatole, to the City of Dallas, to the members of the Alliance who always contribute so substantially to our meetings, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Interim Meeting of the House of Delegates.

Mister Speaker, this concludes the Report of the Committee on Rules and Credentials, and we recommend its adoption.

APPROVAL OF MINUTES: The Proceedings of the 163rd Annual Meeting of the House of Delegates, held in Chicago, Illinois, June 7–11, 2014, were approved.

ADDRESS OF THE PRESIDENT: AMA President Robert M. Wah, MD, delivered the following address to the House of Delegates on Saturday, Nov. 8.

Mister Speaker, members of the Board of Trustees, distinguished delegates, friends:

At my inaugural, I spoke of tradition versus convention. The link between preparation and innovation. Health IT. Advances in military medicine. Women's health. My Chinese heritage. And a couple of sentences about "Star Trek." So the press coverage surprised me. One headline said "New AMA President beams into office." Another quoted the Prime Directive.

Today, I'll talk about the view of health care from my vantage point as AMA president—and about the great things the AMA is doing on behalf of patients and physicians. And let's get this out of the way—I'm going to talk about "Star Wars."

In my travels, I've had attentive audiences eager to hear our message. I thank you all for your warm hospitality during my visits. I've spoken about AMA's traditions—and their impact today. I want to tell you now about how we're mobilizing that tradition – and putting it to work in Washington and in the states. In the process, perhaps uncover a few cosmic truths.

You know I like "Star Trek." I'm also a big "Star Wars" fan, a movie with its own mythology. In fact, in 2001, "Jedi" was reported as the fourth most popular religion in Great Britain. "Star Wars" is also the source of a nickname when I first started in medicine. As an OB-GYN intern, I frequently got the call from the emergency department when a woman came in. So often, in fact, that the staff started calling me "Obi-WAH-Kenobi."

I'd like to think it was for my mystical medical skills, or that I could at least cloud their thinking with a Jedi mind trick. I knew I'd arrived when I was summoned to see a woman with abdominal pain, and the chart was marked "Obi-Wah called." Left unspoken was the phrase "You're our only hope." So I became "Obi-Wah." It could be worse: Jabba the Hut. Chewie the Wookie.

"Star Wars" also reminds me of our own struggles at the AMA against the dark sides of the Force: public and private bureaucracies, red tape, predatory lawsuits, broken, busted and constricting formulas. In this high stakes environment, Master Yoda offers a simple but powerful directive for our work: "Do. Or do not. There is no try."

SGR

"Do" we have, to end the sustainable growth rate developed a long time ago, in a reality far, far away.

Last spring we made another run through the trenches, firing proton torpedoes to destroy this Death Star. We did come away with a viable alternative to the SGR and achieved what we didn't have before, a framework to end the SGR, with bipartisan and bicameral support, backed by more than 600 physician groups.

We're now delivering this message: Congress must eliminate the SGR in the lame duck session. Why? Because it's essential to sustainable practice and preserving access, and because it makes perfect sense. Together, we have an opportunity to show the American people that Congress can work together to pass meaningful legislation to strengthen Medicare. We will work with you—and we will work on our legislators—as we push to end the SGR. Check www.FixMedicareNow.org for the latest on these efforts. We're doing everything we can. It might not happen during this lame duck session, but the end of SGR is not a matter of if, but when.

ICD-10

Here's an interesting fact: Each of the six Star Wars films has this line: "I have a bad feeling about this." That's a common reaction to ICD-10. If it were a droid, ICD-10 would serve Darth Vader.

We'd see 13,000 diagnosis codes balloon into 68,000, a five-fold increase. Sucked into a jet engine? Burned by flaming water skis? Yes, there are codes for that. We all know ICD-10 is expensive to implement. We don't know if it will improve care. For more than a decade, the AMA kept ICD-10 at bay and we want to freeze it in carbonite!

Sunshine Act

Speaking of implementation problems, that brings me to the Sunshine Act. Many of us shared the same reaction: “I have a bad feeling about this.” Again, those instincts were correct. Financial interactions with drug and medical device manufacturers are now reported online to the public.

The AMA did get some provisions to give physicians a chance to review and correct data before it’s posted. Unfortunately the Sunshine Act has already burned some of us. The review website was supposed to go online in January. That didn’t happen until August. Remember the Healthcare dot gov fiasco? The same contractor designed this one. It has a 300-page instruction manual—longer than the blueprints of the Death Star!

Then there’s the incomplete or inaccurate physician data. For instance, one Baltimore surgeon was surprised to learn that, according to the database, health care companies had lavished him \$78,000 in food and beverages. It was actually for consulting work but was misclassified. Of the 550,000 physicians affected by the Sunshine Act only 26,000 had a chance to review their data and correct any inaccuracies.

Let me be clear, the AMA wants transparency. It helps patients make informed decisions about their medical care, but a glitchy website, no time for review and revision, and CMS’s own admission of problems with fully one-third of the data cast doubt on ALL the information on the site.

MIS-information leads to misinterpretations, harms reputations and undermines patient trust. And it discourages the delivery improvements that benefit those very patients. Most relationships with industry drive innovation and advance professional medical education. It makes for better physicians and more effective treatments.

We’re making an impact. Last week, CMS came around to the AMA’s view that speakers contributing to independent continuing medical education are not subject to reporting. This will encourage the exchange of information. We led the way on this. We will continue to work with CMS to make sure the Sunshine Act enhances transparency by using data that is accurate and in context.

EBOLA

Accurate information, presented in context, can also save lives. As you know, Dallas had the nation’s first Ebola patient. Obviously cause for concern, but misinformation and lack of information led to panic and paranoia. The AMA is looked to for reliable information, so check out the AMA’s online Ebola Resource Center for updated information from the CDC, *JAMA* and other public health groups.

And in addition to our efforts to prepare for and treat Ebola, a sharper focus by the US and the international community is essential to contain the outbreak in West Africa. As I said on “Face the Nation,” the dynamic nature of this disease requires a dynamic response. We need to talk to—and learn from—each other. I have every confidence in the CDC and in our team effort, but this fight can’t be won by one person or one entity. We have to stand together.

So the AMA, hospitals and our partners in nursing put forth a plan to manage care of Ebola patients. We must ensure that all hospital and clinical staff can safely provide quality care. And that nurses, physicians and staff have the proper training, equipment and protocols to stay safe while providing that care. Make this a time for preparation, not panic.

EHRs

Accurate information, transmitted in a usable way is also the promise of Electronic Health Records and a challenge for all physicians in the decade to come. At the AMA, we see the vast potential to improve patient care and safety through EHRs, telemedicine and the exchange of data. We also know change can be difficult. Faced with this monumental task of transition, a lot of physicians have thought: “I’ve got a bad feeling about this.”

EHRs are difficult to use, eat up hours in data entry, interfere with face-to-face patient care and degrade documentation. Meaningful Use exacerbates these issues. So we want changes in how the government regulates EHRs so vendors focus less on federal mandates and more on the needs of their customers, physicians. We’re

calling for a more flexible approach to meaningful use, expanded hardship exemptions, improved quality reporting and solutions to usability issues. We cannot let the technology rule us; we must rule the technology. Like a Jedi warrior, be not averse to technology, but don't rely on it alone, at the expense of our own senses, training and clinical acumen.

MU, PQRS, VBM

Some issues transcend both the SGR and EHRs, and pose new threats to Medicare's stability. And once again, a lot of physicians are saying: "I've got a bad feeling about this." Physicians providing care to Medicare patients could be swamped by a tsunami of penalties adding up to more than 13 percent by the end of the decade, this atop the 21 percent cut physicians already face if SGR isn't stopped.

It's not just the sequester. It's the patchwork of laws and regulations such as the Meaningful Use program, the Physician Quality Reporting System, the Value-based Modifier Program. It sounds confusing. It is, enough to stump even the protocol droid C3PO. This hodgepodge cuts physicians' time with patients, wastes energy and resources and fuels professional dissatisfaction. And, ironically, it discourages the very investment in new technology and new approaches to the delivery of care it's supposed to promote.

They aren't aligned, forcing physicians to register and report their information over and over again, over many formats. The AMA wants it streamlined. Doctors should be able to make a one-time report to meet requirements for all Medicare physician quality programs. Report once, use many, and they should create the efficiency and improvements in care we were promised.

Beyond reporting problems, you have to meet 100 percent of Meaningful Use requirements. It's all or nothing. It's unfair, unrealistic and unworkable. Thanks to heavy pressure from the AMA, CMS did reopen the hardship exception to avoid penalties. The new deadline is November 30. The AMA encourages all physicians concerned about a penalty to apply.

Telemedicine

A more meaningful technology is telemedicine. The AMA is at the forefront of this movement; we've developed policy to guide lawmakers and we're driving it forward. We're showing how telemedicine can deliver the right care at the right time in the right place for patients using real-time interaction through online portals, remote monitoring and store-and-forward practices. Data can be sent from patient to physician—like a follow-up photo of a suspicious mole to their dermatologist—or a physician can follow results of a patient's blood pressure or glucose readings, or patients and physicians interacting through secure video services. Not a hologram of Princess Leia delivering an urgent message, but better—a two-way communication, not a one-way plea.

Patients that use telemedicine are better at managing chronic conditions, which improves outcomes, reduces costs and expands access to care. To comply with local laws, physicians need to be licensed in the same state as the patient, not on the other side of the globe. This requires a streamlined licensing process to practice telemedicine in multiple states. We applaud the Federation of State Medical Boards model to expedite licensing. It would help telemedicine flourish and states would keep their authority to protect patients.

We need coverage and reimbursement of telemedicine services and fewer restrictions in Medicare. We want patients to use it if they need it. Lift geographic restrictions. Free up its use in alternative payment models, and cover the dual eligibles so they can use these services.

Telemedicine, SGR, EHR, ICD-10, Sunshine—all part of the vast galaxy of issues the AMA is addressing on behalf of all physicians and patients. All are in addition to—and supported by—the three strategic goals we share, our "Moonshots" to improve health outcomes for our patients, improve physician satisfaction and improve the education of our future doctors.

Our hard work is earning the trust and support of more and more physicians. Membership is up for the fourth straight year, kind of like the box office for "Star Wars" and its sequels and prequels. Our AMA has accomplished much this year, but none of us can go it alone. We face issues that make us think: "I have a bad feeling about this."

But recognizing potential problems is the first step toward overcoming them. To do so, you first must start. We've taken that step, and we are fighting that "bad feeling" with positive action on behalf of physicians and our patients.

This year, I traveled across this country and sometimes across the planet. On these long flights, I'd love to make the jump to light speed in the Millennium Falcon. Instead, it's more like flying the Daily Pigeon in the middle seat. But I'm grateful for the privilege of representing our AMA. I'm seeing how physicians are navigating today's health care challenges and how the AMA can help.

Obi-Wan said "The Force is an energy field created by all living things. It surrounds us and permeates us. It binds the Galaxy together." In that way, the House of Medicine—and the power generated and put to purpose by America's physicians, acting together through the AMA—is a Force to reckon with indeed.

That means all of us, speaking in one voice at the AMA, speaking so loud on behalf of our profession and our patients, that all can hear. This, as Obi-Wan observed, "Can make us more powerful than you can possibly imagine." May the Force be with us.

REPORT OF THE EXECUTIVE VICE PRESIDENT: The following report was presented by James L. Madara, MD, Executive Vice President of the American Medical Association, on Saturday, Nov. 8.

Mister Speaker, Mister President, members of the Board, delegates, guests:

Five months ago, I shared a personal story of my childhood diagnosis of cavernous sinus thrombosis made by a Philadelphia ophthalmologist, Dr. Spaeth. After my speech, I learned from our ophthalmology colleagues, that Dr. Spaeth had a son who followed in his dad's footsteps and became an ophthalmologist himself.

I've since connected with the son, George Spaeth, sharing the impact that his dad had on me—how his dad inspired me to become a physician. It was great. I also learned from someone sitting behind our ophthalmology colleagues last June that there was a flurry of discussion as I shared my story. It seems some of these colleagues agreed with my diagnosis, while others weren't so sure and thought an A-V malformation must have also been involved. Now as you know I really have tremendous respect for this House. But I have to tell you, this has been my diagnosis for more than 50 years, and I'm keeping it!

That story from my childhood was folded into the message of the great power of our physician voice and the respect and influence it commands from the American public and other stakeholders both inside and outside health care. Last June, I challenged you to turn up the volume of that voice by providing more cohesion to it in improving the future of health care for America's patients and physicians. Well, we're making progress.

Dr. Wah just highlighted the many ways the AMA is leveraging its voice in our nation's capital to address the many challenges facing our profession. Likewise, thanks to our collective voice we are advancing the AMA's strategic plan on all fronts. I'll update you on the progress we're making, but first I want to share an experience that captures how the AMA is working differently and the attention it's generating.

As many of you know, just a few weeks ago, the AMA was the global partner of the prestigious TEDMED 2014 speaker series. This annual event brings together dynamic speakers from across the world to share innovative and thought-provoking ideas on how to improve our lives and the health of the world around us.

TEDMED speakers challenge each of us to see the world differently and re-imagine what is possible. Collectively, they offer a transformational voice for seeing the world not just as it is, but what it can be. They inspire us to challenge the status quo. They point us toward new and different ways to analyze and solve problems like never before.

Re-imagining possibilities, challenging the status quo, identifying new solutions—it's precisely what the AMA is doing. At TEDMED, we had the opportunity to share the AMA's work and the dramatic steps we're taking to improve the health of the nation, and we made an impression. Many we spoke to were impressed and shared great enthusiasm for our work. Some even sent personal follow up notes.

I received this from a NYU neurosurgeon pioneering simple new techniques to detect early brain injury, work that interestingly is now receiving support from the New York Giants. “You have changed my preconceived notions about the AMA,” she wrote, going on to praise the work the AMA does.

Another physician, a member of Harvard’s faculty who develops novel nanoparticle treatments wrote: “My meeting with the AMA was the high point of TEDMED for me.” But perhaps the testimonial that impressed me most came from Jay Walker, founder of the TEDMED talks. In welcoming the speakers he said the AMA’s work was at the “forefront of disruptive innovation” and he looked forward to exploring how TEDMED and the AMA could work together in the future.

Over the centuries, disruptive innovation—and those who have been catalysts of it—have changed society and the world for the better. So, we’re in good company. So where do things stand with our mission area strategic plan?

AMA Strategic Plan Update

Let me start with our work to enhance physician satisfaction and practice sustainability. We are advancing along two tracks: the first is aimed at improving physician practice support, and the second addresses specific issues in our health system.

Regarding the first, I am pleased to announce that the first four modules in our new Steps Forward series are now in beta testing. STEPs Forward—which stands for Solutions Toward Effective Practices—is our new online platform providing interactive, educational modules to help physicians address common clinical challenges in their practices. The first four of these modules address:

- Systematic prescription renewal
- Pre-visit planning
- Expanded rooming and discharge, and
- And, collaborative documentation

Physicians and their practice managers can use these modules to help improve clinical efficiencies. The modules even offer CME credit, so physicians can earn while they learn. I encourage you to view these modules at Steps-Forward.com. We’re looking for your feedback. We are using this beta testing period to refine and improve these current versions for launch next summer. So tell us what you think.

These modules attack simple things that drain physician time, for example, the non-systematic approach to prescription refills can waste nearly an hour of physician time per day unnecessarily. We know this from our quantitative work in physician practices. And we know you want your hour back!

On the other front, the AMA is addressing three health system issues to improve the current environment for physicians. These include:

- Understanding and improving new physician payment models;
- Ensuring physician leadership in new practice-model organizations;
- And, working to improve the usability of EHRs

With regard to new physician payment models, we are again partnering with RAND, but this time, we’re measuring what impact new payment models are having on physician practices. This research, active in six diverse markets across the country, is wrapping up. We intend to release the findings early in 2015 and then act on those findings. We’ll use these findings not only to educate physicians on the pros and cons of these new models, but also to help us identify areas where AMA advocacy can help improve them as they evolve. It is entirely possible we will conclude that some models are unworkable for physicians—or perhaps only workable with substantial modifications.

We’re measuring “workability” with tools we developed the year before last which directly assess physician satisfaction and dissatisfaction. It’s a point I’ve made before, but it bears repeating: so much of the work in our focus areas links back to our advocacy work, helping to inform and strengthen our advocacy efforts.

Elsewhere, the AMA is working to ensure physicians have an empowered voice within evolving practice models, including physicians who choose to be employed. In new work with the American Hospital Association we are exploring ways physicians and hospitals can be more collaborative. The AMA and the AHA are now developing a core set of principles to ensure physicians have leadership roles in hospitals as well as emerging care models.

You know that “physician alignment” has often been used as code—code where “align” really means “do as I say.” That’s not good for physicians. It’s not good for patient care. And we need to ensure that leadership and decision-making incorporates the authentic voice of physicians.

In regard to the remaining issue, enhancing EHR usability, as Dr. Wah mentioned, our list of eight priorities to make EHRs more physician-friendly provides a critical framework to engage regulators and vendors on improving the current mess. EHRs will never realize their full potential unless they work well for physicians, and we’re going to make it happen.

Now, turning to our innovative work on undergraduate medical education, just two months ago, our 11 consortium schools gathered with other medical school leaders at Vanderbilt. The strides made in just the first year are truly impressive. Let me give you just a few examples.

At Penn State University, 30 percent of its first-year curricula has been overhauled to incorporate new content focused on areas critical to the future delivery system: quality, team-based care, communications and health care financing. Equally impressive are the changes occurring outside the classroom. First-year medical students are now serving as patient navigators. In this role, students are linked to local clinics where they help patients handle insurance, find community resources and coordinate complex care issues. They also provide support and educate patients about their illnesses. This novel approach not only provides a valuable resource to patients, but it gives these medical students a much better understanding of the current delivery system and offers greater context.. Additionally, studies have shown improvement of patient outcomes with use of such navigators – a triple win!

Meanwhile, NYU’s emerging curriculum is using virtual patient panels—based on authentic clinical data—to better educate students on the use of big data in patient and population health management. Already in the first year, the approach is identifying potential areas for system improvements in quality and value. A brief taste from the multiple innovations that are evolving in our participating schools, the key here is sharing across the consortium so that the pieces of innovation converge to a new model of 21st century medical education.

Finally, our work in Improving Health Outcomes has turned a significant corner. We recently completed the pilot work for both our diabetes prevention and hypertension control initiatives. Now we are pivoting toward spreading effective strategies to help more physicians tackle these conditions in their practices.

In our prediabetes work, we are taking what we’ve learned from our pilot practices, and moving into the remaining states where CMS awards allow Medicare beneficiaries to attend the diabetes prevention program for free: Arizona, Ohio, New York and right here in Texas. As we expand geographically, we are also trying to expand the scope of these efforts to include not only older adults, but all adults with prediabetes.

We’ve also begun working with the Centers for Disease Control and Prevention and several specialty societies to determine how we can speak with one voice when we communicate with physicians and patients about prediabetes. It so happens that November is Diabetes Education Month, and it’s critical that we rally organized medicine around this urgent issue—86 million American adults have prediabetes, and only one in ten knows it. We can do better.

In the coming months, you’ll be hearing more about ways that the AMA and CDC are teaming up to prevent diabetes, and I think you’ll be pleased by the opportunities that will be available to your organizations and your members to join this effort.

Meanwhile, our collaboration with Johns Hopkins Medicine to better manage hypertension has yielded a framework that we call the MAP for optimal hypertension control. “MAP” stands for:

- Measure accurately;
- Act rapidly; and
- Partner with patients, families and communities to promote self-management

We are beginning a second phase of work which will focus on the “P” in the MAP. It is focused on developing a set of best practices for partnering with patients, families and communities to promote self-management of hypertension. This practice-level work is crucial in developing processes and tools that physicians will truly find useful.

So, that's a quick overview of where things stand in our three focus areas. Presented as “moon shots” just two years ago, all now have tangible traction and national visibility.

Power of Mission

As you can see, our work improving outcomes for our patients, our medical students and our physicians also deeply resonates with our core mission: to promote the art and science of medicine and the betterment of public health. Still, I'm occasionally asked: Jim, why this work? Why these areas?

My answer is always the same: it's where our AMA mission points us, underpinned by an array of policies passed by this House. Throughout the AMA's 167-year history, our mission has been our moral compass and the road map that guides our work. Better than GPS or a Google map, our AMA mission has charted a course for accomplishing extraordinary things.

The AMA was at the front lines winning the fight against the wide spread quackery in the 19th century. We led the work that went into the restructuring of medical education in the early 20th century. History buffs among you will recall that early work of the Council on Medical Education, published in two *JAMA* papers, ultimately led to the Flexner report. And we led the war on tobacco and subsequently the call for the civil and compassionate treatment of AIDS patients at the end of the 20th century.

The AMA's legacy of leadership in tackling the most important health issues and putting the needs of our patients and the public's health first and foremost has served us well. Call it leadership. Call it altruism. Call it doing the right thing. But when we are true to our mission, we earn the public's respect, we gain influence with policy makers, and we gain stature with thought leaders across health care and beyond.

And let me be clear, being true to our mission does not mean minimizing all that we do to help physicians. Rather, being true to our mission gives power to our voice both in Washington and with the public. Now more than ever, our advocacy on behalf of physicians—on your behalf—is absolutely critical. And these efforts continue full throttle. We know our profession is a noble calling. We will protect and preserve that calling.

Shaping a better future for health care in this country is not an “either-or” proposition. Instead it is one that demands we advance and activate all core components of our AMA. Working together, we can lead the way to improving health outcomes for our patients—attacking the enormous burdens of chronic disease. Working together, we can ensure the next generation of physicians is trained by 21st century standards. And working together we will shape a more satisfying and sustainable practice environment for physicians, an environment so challenged in its current state.

These are audacious goals, our moonshots. But the AMA should aspire to nothing less. Our mission won't allow it.

Together, we are breathing new life into our mission statement for each other, for the next generation of physicians, for our patients and for a healthier nation. That's the power of our mission. That's the power of our AMA.

Thank you.

REMARKS FROM THE SECRETARY OF VETERANS AFFAIRS. The following remarks were delivered to the House of Delegates by US Secretary of Veterans Affairs, Robert A. McDonald on Saturday, November 8.

Thank you, Dr. Wah. And thank you for your many years of service to Navy medicine. We at VA often tell employers that veterans never stop serving. Dr. Wah is an example of that—23 years of service in the Navy, 17 years as a member of the House of Delegates, a year as chair of the AMA Board of Trustees, and now AMA president.

Let me also thank Dr. Gurman, Speaker the House of Delegates, for the invitation to be here today, and the rest of the AMA's leadership, including Dr. McAneny and Dr. Madara, for your support for and help in drafting the Veterans Access, Choice, and Accountability Act of 2014. I'll have more to say about the Act later.

Distinguished members of the House of Delegates, Ladies and gentlemen:

As the principal policymaking body of the Nation's largest medical association, you know that the Department of Veterans Affairs is in the midst of overcoming problems involving access to healthcare. We own them, and we're fixing them.

But I know you also know that VA has a legacy of excellence, innovation, cutting-edge research and achievements in healthcare delivery that is as broad and historically significant, as it is profound—and often unrecognized.

There's something else. Right now, VA has before it perhaps its greatest opportunity to enhance care for veterans in its history. Others know that truth, as well. Last July, Sloan Gibson—VA's deputy secretary, my West Point classmate, and a friend for almost 40 years now—met with Harvey Fineberg, distinguished clinician and healthcare leader. When Sloan commented that VA could accomplish more in the next 2 to 3 years than we could have in 2 to 3 decades, Dr. Fineberg immediately corrected him: "No!" he said, "VA can accomplish things now it never could have accomplished!"

He's right. We're in an extraordinary position. We have an opportunity to not only right wrongs, but to re-frame perceptions about VA by lengthening our lead in areas where we've always excelled, taking the lead in service delivery areas that are lagging and charting new ground in emerging or evolving areas of healthcare.

The problems we face are serious. The President, Congress, veterans' service organizations, taxpayers and VA's rank and file all understand the need for immediate reforms to achieve the three non-negotiable goals we set for ourselves more than two months ago:

- Rebuild trust w/ veterans and stakeholders,
- Improve service delivery, focusing on veteran outcomes,
- And set a course for long-term excellence and reform.

Toward that end, I've been on the road—traveling to 41 VA facilities in 21 cities; meeting with hundreds if not thousands of veterans, VA physicians and other employees, VSOs and other stakeholders; and discussing the issues with Members of Congress, VSOs, unions, and myriad other partners.

Based on what we've heard—and the lessons I've learned about mission-driven corporations, strong institutional values and good management practices during my 33-years at Procter & Gamble—we've wasted no time in developing a healthcare "Blueprint for Excellence." This blueprint is critical to achieving the third of our nonnegotiable goals—setting a course for long-term excellence and reform. The Blueprint lays out 4 broad themes and supporting strategies for transformation.

First, we must improve the performance of healthcare NOW. There's a lot at stake: We deliver 240,000 episodes of care each day, more than 90 million scheduled appointments in 2013 alone. And we perform 400,000 surgical procedures annually, nearly 1,100 per day.

Second, it's imperative that we re-set VA's culture to put a high premium on job performance and the strong VA institutional values that support it: Integrity, Commitment, Advocacy, Respect, and Excellence. These attributes go to the heart of our mission and dictate how employees act, relate to veterans and each other, and treat the 6.5 million unique patients we see each year. By "living" VA's core values, we can go a long way toward overcoming the challenges before us.

Third, VA must transition from "sick care" to "healthcare" in the broadest sense. Many of you are already putting more stress on prevention and healthy living, consistent with the AMA's strategic focus on "improving health outcomes," which targets preventable diseases like heart disease and type 2 diabetes. VA needs to do more of the same, helping veterans take charge of their own health.

Fourth, we must develop efficient, transparent, accountable, agile business and management processes to support the span of care, services, and programs we deliver. Above all, it's imperative that VA regain and retain a laser focus on its customer base—that means everyone from the 90-year-old veteran who crossed Omaha Beach to the 19-year-old who battled insurgents in Afghanistan's "Valley of Death."

That said, VA's vision for change is not only veteran-centric, but veteran-driven—putting our customers in control of their VA experience. The healthcare industry, itself, is moving toward a more customized, consumer-centric version of primary care access.

At VA, the challenge is a more complicated because healthcare is just one of nine VA lines of business—the others being benefits like life insurance, mortgage insurance, education, pensions, disability compensation and memorial affairs.

Our solution to the patient-experience challenge is called MyVA. We call it MyVA because that's how veterans should view us—as an organization that belongs to them and provides quality care in the ways they need and want to be served. MyVA means:

- Shaping VA through a better understanding of veterans' needs and preferences.
- Providing a single-entry, user-friendly access so they can effortlessly navigate VA care and services.
- Removing cumbersome processes and procedural obstacles that frustrate users.
- Providing the full spectrum of resources—financial, human, and otherwise—to serve them efficiently and effectively.
- And, last, empowering employees at the lowest level possible to respond and react quickly and knowledgably to veterans at each point of interaction.

To do this, we're looking at ways to restructure and reorganize, combine functions, simplify operations, make process improvements, leverage technology, and enhance efficiency and productivity. It's a 360-degree effort designed to present veterans with a seamless, integrated, and responsive VA—no matter whether they come to us digitally, by phone, or in person.

Our goal is simple: Provide quality medicine and first-rate healthcare delivered with the same proactive, real-time, courteous, coordinated service as the top-ranked customer service companies in the country. The fact is, VA already has that type of service excellence in many areas. For the past decade, the American Customer Satisfaction Index, the ACSI, has ranked VA's National Cemetery Administration as the top customer-service organization in the Nation—public or private. Better than Google, Lexus, and all the rest.

And since 2004, the ACSI has consistently shown that veterans receiving both VA inpatient and outpatient care give VA higher satisfaction ratings than patients at most private hospitals. With the right strategies and enough support, there's no reason why we can't scale that performance excellence VA-wide.

Right now, one of the biggest challenges we face is the shortage of physicians and other healthcare professionals. It was an underlying reason for the problems that occurred in Phoenix and elsewhere. And that's why, as part of a national recruitment effort, I've gone to 11 of the nation's medical and nursing schools—Duke, UC Davis, UC San Francisco, Dartmouth, University of Vermont, Johns Hopkins, Howard, Morehouse, Massachusetts General and a few others—to personally tell students about VA's great mission and encourage them to join a revitalized Team VA in caring for those who defend us. Audiences everywhere have been welcoming and interest is high.

Here's what I tell them: At VA, we have the most inspiring mission in government and the best clients in the field of healthcare—great reasons to work at VA. Beyond our noble and respected mission, and the exceptional people we serve, VA offers practical reasons to work for veterans.

- The Veterans Access, Choice, and Accountability Act, or "Choice Act," which the AMA helped write, increased VA residency positions by 1,500.
- It also doubled the amount of our education debt reduction payment—from \$60,000 to \$120,000!
- VA also offers recruitment, relocation, and retention incentives.
- And, as part of the drive to recruit the best and brightest, we've eased the pay disparity with the private sector—always an issue—through salary increases for VA's physicians and dentists.

The demand for VA care will not decrease any time soon. The nation's been at war for over a decade, and we'll continue to be caring for many of our severely wounded and ill veterans for decades to come, if not a lifetime.

In a still recovering economy, the number of veterans seeking our services continues to grow steadily, and we continue to serve a population that is older, with more chronic conditions and less able to afford care in the private sector.

The Choice Act goes a long way toward enabling VA to meet the current demand for care, and to support the large-scale reforms we're making for long-term excellence. The law provides \$5 billion to hire more physicians and other medical staff and \$10 billion to fund additional purchased care while building internal capability.

As most of you know, VA has always sponsored non-VA care in extraordinary circumstances:

- Like geography, where rural veterans can't easily get to a VA facility;
- Technology, where it makes sense to refer veterans elsewhere for highly specialized procedures;
- And to cover temporary shortfalls in staffing and other resources.

We recently stepped up the use of purchased care to respond to the shortfalls that came to light last spring. From mid-May through September, VA authorized non-VA care for over one million veterans—46% more than in the same period last year.

Now, with funding from the Choice Act, we are taking purchased care to a new level with our new Veterans Choice Program.

- Just this week, we began phased implementation of the program: We stood up a special call center to verify eligibility and answer questions about the Veterans Choice Program. The number to call is 1-866-606-8198.
- We have also begun extending the option of purchased care to eligible veterans who live more than 40 miles from a VA facility ... and in the coming month, we'll do the same for those who have been waiting too long for an appointment.
- By "too long," I mean more than 30 days from the clinically appropriate date or the date preferred by the veteran—that's our new standard.
- In a few months, every veteran enrolled for VA healthcare will have a new Veterans Choice Card, to use for authorized non-VA care in the future, should they need it. The first Choice Cards were mailed out this week.

The Veterans Choice Program can be a big part of the solution to our current access problem, but the new law is extremely complex, and we need to make sure we get things right.

Fragmentation of care could become a problem as veterans move back and forth between VA and the private sector. We need to make sure veterans are cared for by physicians fully knowledgeable of their medical history, that they get the screening and preventive care they need and that VA and private-sector providers don't duplicate services unnecessarily. So we need to configure the Choice program in a way that enables all of the doctors caring for a veteran to work together as a team, no matter who's paying the bill.

We're also working to make seeking and receiving purchased care as easy as possible for both veterans and physicians. We need you to participate in the program, and we know you won't if it's too much trouble. The same is true of veterans: They need to know that their care is authorized by VA and that they'll get the care they need. If they don't, they may resist going outside VA and put off being seen.

For those reasons, we have signed contracts with two healthcare companies with experience running similar programs—TriWest and HealthNet—and we'll be working with them to administer the Choice program in the best way possible.

Purchased care is not a replacement for a strong and vital veterans' healthcare system. Veterans need VA, and Americans everywhere—indeed the global community—benefit from VA.

- From VA research leading to major breakthroughs and advances in medical science and care—like the licensing of the shingles vaccine as a result of a VA Cooperative Study;

- From VA training 70% of America's physicians—62,000 medical students and residents, 23,000 nurses, and 33,000 other health professionals—each year.
- And from VA's highly specialized knowledge and know-how to deliver clinical and rehabilitative care to those who have “borne the battle.”

But VA cannot accomplish its healthcare mission as a stand-alone system. It is naturally and appropriately part of the larger healthcare community, facing the same challenges many of you face, and benefiting as you do from exchanges of expertise and from the movement of patients and providers within the community.

The growth in purchased care sets the stage for re-envisioning new relationships and reenergizing existing partnerships between VA and the private sector—as well as other parts of the public sector—for better care, better health, and better value.

Purchased care addresses some of VA's current problems, but, as important, it opens the doors to other transformative aspects of patient care. In care coordination and interoperability, for example—challenges common to both public- and private-sector healthcare providers.

If VA and private providers are caring for the same veteran-patient, we're in a position to collaborate, to share information and knowledge. There's a potential to leverage improvements in electronic health records by developing a public-private platform and infrastructure to generate new ways of using patient information and data, new ideas, new approaches and new solutions for better patient care.

Increased purchased care also has the potential for increasing high-value care—particularly in reducing medical waste and redundancies. Here again, because we're working in tandem, there's practical, real-time opportunity to ask ourselves, “How do we prevent costly redundancies in x-rays, MRIs, blood tests, and countless other tests?” More than that, asking, “How do we reduce unnecessary testing, period?” It gives us the opportunity to tackle these types of issues and develop answers and solutions that have import across the medical community.

It all comes down to what Dr. Fineberg said, we have an unique opportunity before us at VA to “accomplish things now [we] never could have accomplished.”

Employees across the Department have rolled up their sleeves, and work is underway to make the changes to VA systems, procedures, and culture that the law requires. We've done a lot, but there's a lot left to do if we're to right the wrongs, institute reforms and employee accountability, modernize, and recruit the numbers of healthcare professionals we need.

We are committed to doing the right thing—delivering the right programs … in the right way … at the right time … for those special Americans we serve.

As we go forward, one thing's clear. VA cannot do what needs to be done, and accomplish its goals, without a full complement of partners—public, private, and volunteer. We don't have all the answers. We can't operate in a vacuum—no 21st century organization can. That's why we're aggressively leveraging our existing relationships and affiliations, and forging new ones. Here are a few examples:

- VA's partnering with the Institute of Medicine in a study of access standards and wait-time metrics.
- We've entered into a first-of-its-kind partnership with Walgreens to provide vaccinations to veterans—Walgreens will share its immunization records with VA to ensure we have complete patient medical records.
- We're collaborating on a new nursing academic partnership focused on psychiatric and mental healthcare—a key area of care for VA and for DoD.
- We're partnering with DoD to improve recruitment of recently or soon-to-be discharged military healthcare professionals.
- We're expanding a pilot program to bring combat medics and corpsmen into VA facilities as clinicians.
- We're partnering with the Northern Virginia Technology Council to establish a pro-bono technology task force to review VA's scheduling system and make recommendations for improvement.
- We're setting up a consulting Board of Physicians—comprising the foremost medical minds in the Nation—to advise me on industry best practices.

In my three months at VA, one thing stands out as I've traveled around the country—the goodwill and support shown by the medical community to VA, its mission, and its achievements. Harvey Fineberg, Jonathan Perlin, Ken Kizer, Navy Surgeon General Matt Nathan, Morehouse President Valerie Montgomery Rice, your own Executive Vice President Jim Madara, and so many others from both the public and private sectors, have all expressed their willingness to publicly speak out and "right the record" in telling the VA story.

We're taking advantage of their offer. Right now, VA's in the process of creating a VA Alumni Group—a "Friends of VA" committee of sorts. Our thought is to gather interested leaders in medicine and the healthcare industry, brief them regularly on VA operations, initiatives, and performance, and solicit their input and assistance.

One of our objectives is to insert a degree of balance and truth to the one-sided conversation about VA care and services. You can help with that. You can share with colleagues and laypersons your positive experiences working with VA and your professional perspective on the challenges VA and other healthcare providers face.

So I'd like to invite you to consider becoming a part of this initiative. We want and need your professional advice. We seek your input as we move forward in implementing the Choice Act. We welcome your participation and collaboration across the spectrum of care.

Once again, thanks for this important opportunity to speak this afternoon and for your support for the nation's veterans. I look forward to working with you to improve healthcare for veterans and all Americans.

Thank you.

REMARKS OF THE CHAIR OF THE AMPAC BOARD: The following comments were offered by John W. Poole, MD, on Saturday, Nov. 8.

Good afternoon. I travel with my own soapbox now. The nurses back home at work gave me this. I think they were trying to send me a message saying that the daily harangue I give my colleagues, "If you're medicine, you're in politics," they've heard it one time too often. But let me get on my soapbox, okay?

My name is John Poole. My name is John Poole, and I'm here to ask for money. That's the last time you'll get to hear me say that as Chair of AMPAC. So since this is the last time that I get to lecture you—I mean address you—I'd like to say why I personally think AMPAC is so important.

In 2002, New Jersey, like many states in the country, was in the midst of a tort reform crisis. Our largest medical liability insurer had gone bankrupt. Many carriers left the state and all of a sudden doctors were scrambling to find insurance. And many physicians, quality physicians that found out that if they had been involved in a lawsuit for the past five years or so, they were uninsurable or they were put in a pool, a hundred, 200, sometimes \$250,000. And all of a sudden I realized, you know, it didn't matter what college I went to. It didn't matter that I got tortured through organic chemistry. It really didn't matter how hard I worked in medical school, how hard I worked in surgery residency, how many operations I've done. What really mattered is that my fate came down to 120 people in the New Jersey legislature, only one of which was a physician. And I said to myself, you know, the solution to that is we have to educate the legislature, and we hopefully elect candidates that understand our issues. So I have been the PAC Chair in New Jersey since that time. And I think the same holds true on a federal level if you think about the doctor-patient relationship or practice sustainability. I don't think it's ever been more threatened by the whim of 100 Senators and 435 Representatives. I mean, clearly, if you're in medicine, you're in politics, especially at this point.

So speaking if you're in medicine, you're in politics, I'd like to say, first of all, congratulations to the California Medical Association for that huge victory in getting Proposition 46. You know, if the trial liars—I mean, trial lawyers—had won that one, who knows what they would have been embolden to do in the rest of the country.

So I'd like to say a few other things. You know, we all pride ourselves on being a patient advocate, but I think being a patient advocate involves more than just the exam room. We took an oath to first do no harm. And unless we reform this system, our patients are going to be harmed. So I think political action is good patient care.

We also pride ourselves on being leaders. That's why we're here. But I think the price of leadership is to set an example. Everybody in this room should be an AMPAC Capital Club member so that when you go home, your colleagues can't use that as an excuse as to why they don't have to join. Right now, only 70 percent of us are members of AMPAC, and that includes at the \$100 level. So I think the price of leadership is that everybody should be a Capital Club member.

You know, I was thinking about it. If 100,000 physicians in the United States, that's less than the AMA membership, donated only \$100, we'd have \$10 million a year. That's \$20 million a cycle. I call that a super PAC, and I think that would send shockwaves through Washington.

So AMPAC allows you the ability to demonstrate that you're a true patient advocate and allows you to demonstrate that you're a leader. But I also think it can show—I think also it can bring you honor. So now I think you're sitting there saying, wow, he's really gone off the deep end with AMPAC politics and honor. But let me explain.

In June of 2013, when I addressed you, I said I was thinking about quoting Shakespeare. And at the time I admitted I was a general surgeon, a non-cognitive physician and that that was above my pay grade. But I'd like to say that I've worked hard on your behalf and I took an online course in how to be a more cognitive physician. So if you will indulge me, I'd like to quote a little bit of Shakespeare and show how AMPAC can bring you honor.

In Shakespeare's King Henry V, it's the eve of the St. Crispin Day feast, it's 1415, and the English Army is surrounded by a French Army that vastly outnumbers them, and they're going into battle the next day. And some of King Henry, V's, lieutenants come to him and say that the men are concerned about the outcome of the battle. And the King says, "Well, let anybody that wants to go home, can go home, because we're going to win the battle and that's going to be more honor and glory for the people that stay." He says, "We few, we select few, we merry band of brothers." In fact, he says that the people at home that are sleeping right now are going to regret that they weren't there with them.

So he says, you know, "From this day to the ending of"—he states that "gentlemen in England now a-bed shall think themselves accursed they were not here." But "from this day to the ending of the world, but we in it shall be remembered, we few, we happy few, we band of brothers."

Of course, you can guess the outcome, the English won a resounding victory.

You know, like the English Army, medicine today is surrounded. We are surrounded by groups that want to control our destiny, they want to define our profession. But we control our own destiny. We define our profession. We define our own Code of Medical Ethics. We define quality of care. That's what being a profession is.

So I think your investment in AMPAC can help you with the honor of saving our profession. You know, when your family or children ask you years from now, what did you do to protect your profession? I don't want to you be like those English gentlemen finding themselves accursed home in bed missing the battle. So I don't want you, and when you look yourselves in the mirror and say, you know what, at medicine's greatest time of need, did I do everything that I could? And so for only \$100, you can then say, yes, I invested in AMPAC and it did everything I could.

I don't want you to live with that lifelong regret. For \$100, I can relieve you of that lifelong regret.

And you know what, for only \$2,500, I'll throw in this tie or a scarf. So if you think about it, you get to demonstrate that you're a true patient advocate, you get to demonstrate that you're a leader and you get to live with the honor of saving our profession. Boy, that's a Texas size deal if I've ever heard one.

So, in conclusion, it has been a privilege and honor for me to serve as Chair of AMPAC these past two years. It's been the thrill of a lifetime. It's been the highlight of my medical career.

I'd like to thank the Board for appointing me. I'd like thank this House for the support you've given me as I spent the last several years trying to shake you down for money. But, most of all, I'd like to thank the fact that this House has given me hope. You know, when I spend too much time in my hospital cafeteria, I need to be put on antidepressants. The talk is, the future is hopeless, our profession is over, I would never want my children to go into this profession, I would never do it again. And yet when I come here, I get energized. And when I go around the

country to my assigned states and I see the House of Delegates and attend the PAC meetings, the passion and the commitment that people bring to this cause, I know that our future is bright.

So for those 30 percent of you that have yet to join AMPAC, I know that's just an oversight and you can correct it this meeting. For those of you that have joined AMPAC, I thank you, my few merry band of brothers and sisters.

Thank you.

REPORT OF THE AMPAC BOARD OF DIRECTORS: The following report was submitted by John W. Poole, MD, Chair of AMPAC:

It is my privilege to present this report to the members of the AMA House of Delegates concerning AMPAC's efforts this election cycle in support of the AMA's federal advocacy efforts.

AMPAC Membership Fundraising

We are happy to report that AMPAC's overall fundraising efforts during the 2014 election cycle have surpassed receipts raised during the 2012 election cycle by 11%. So far this cycle, AMPAC has raised \$2,764,574 compared to \$2,482,668 raised in the 2012 election cycle. Importantly, AMPAC's hard dollar receipts are up 16% over the last cycle. This significant increase is attributed to the continued success of AMPAC's direct mail program along with tremendous participation in AMPAC's Capitol Club.

AMPAC's direct fundraising receipts increased by nearly \$500,000 for a 25% increase over the 2012 cycle. We continue to work with 11 states who act as collecting agents for joint fundraising activities. Unfortunately, revenue from collecting agent states has continued to steadily decline with 2014 cycle receipts totaling \$249,361—a 32% decrease from the 2012 cycle.

Capitol Club participation continued to play a crucial role in ramping up AMPAC's receipts. Through November, there are 903 Capitol Club members surpassing 2013's year-end total and all-time record of 854 Capitol Club members. AMPAC's Capitol Club Platinum currently has 61 members. Capitol Club Gold currently has 278 members and Capitol Club Silver has 564 members. Capitol Club is an important part of AMPAC's fundraising efforts and continues to show robust improvement every year.

House of Delegates participation in AMPAC is currently at 70 percent. With 39 percent of members participating at the Capitol Club level there are 22 Platinum members, 77 Gold members and 96 Silver members. I know we can do better to increase participation in this House. As your colleague and a \$5,000 contributor to AMPAC, I strongly encourage you to stop by the AMPAC booth and contribute. It is not only one of the most important investments you can make in your profession, but it also provides an opportunity to help advance the AMA's advocacy mission.

AMPAC is hosting its annual Capitol Club luncheon on Monday, November 10th and all current Capitol Club Platinum, Gold and Silver contributors have been invited to attend. Highly acclaimed Washington, DC political handicapper Stu Rothenberg will walk us through the aftermath of the 2014 elections and a look ahead to 2016.

Additionally, AMPAC is raffling off an incredible trip for two to Italy in September 2015. The winner of the "All Roads Lead to Rome" sweepstakes will be drawn during the Capitol Club Luncheon on Monday and all current 2014 Platinum, Gold and Silver contributors are automatically entered into a drawing. The lucky winner and a guest will enjoy travel and four-star accommodations for 7 nights through Rome, Florence, and Venice.

Political Action

For the 2014 election cycle, AMPAC spent more than \$2.2 million on behalf of pro-medicine candidates running for the US House and Senate. Working with the state PACs and in a bipartisan manner, AMPAC contributed over \$2 million to candidates (63% Republican and 37% Democratic) who are friends of medicine, in leadership positions, and on key committees. These contributions did more than demonstrate support for medicine's allies in Congress. They facilitated hundreds of strategic opportunities (including fundraising events, dinners, receptions, and one-one-

one meetings) for AMA lobbyists and local physicians to meet with influential members of Congress and directly promote medicine's top legislative priorities.

AMPAC's election year activities also included a robust partisan communications program, comprised of more than 151,000 pieces of mail urging support for Republican and Democratic lawmakers deemed to be good friends of organized medicine. These "Get Out the Vote" mailers were produced in partnership with state medical society PACs and sent to physicians in the states and districts of these specially identified candidates in the final weeks leading up to Election Day.

A total of 349 AMPAC-supported candidates won their elections for a success rate of 95%. And while the cadre of physicians in Congress has dropped from 20 in the current Congress to a projected 17 to 14 in the next (depending on the outcome of a few races still yet to be determined), this is due mostly to retirements and candidates seeking other office. New friends of medicine including Representative-elect Evan Jenkins (R, WV-03), the current Executive Director of the West Virginia State Medical Association, were victorious, however, and we look forward to working with them to advance medicine's agenda in 2015 and beyond.

More immediately, as Congress begins to look ahead to a likely "Lame Duck" session in December, AMPAC's involvement in the 2014 election cycle has certainly helped to reinforce medicine's top priorities, including repeal of Medicare's broken SGR formula.

Political Education Programs

In September, 64 physicians and state society staff attended the annual AMPAC Federation Meeting in Washington, DC. In addition to providing an opportunity for state PAC leaders to come together to share ideas for effective political action, the meeting also provided opportunities for participants to visit Capitol Hill to lobby their state delegations. More than 100 meetings with Congressional offices were held to push for SGR repeal.

In 2015, AMPAC will once again host the Candidate Workshop and Campaign School in Washington, DC to help AMA members become more effective advocates for medicine as both candidates and skilled campaign volunteers. The Candidate Workshop will be held February 20-22 and the Campaign School will be held April 15-19. You are encouraged to visit the AMPAC booth or visit ampaconline.org to find out more about these exceptional programs.

2014 also marked the most successful year for the AMPAC Regional Campaign and Grassroots Seminar program, which is now approved for CME credit. The Seminars are designed to provide training in political campaigns and grassroots lobbying, so that physicians and friends of medicine can help advance medicine's agenda at all levels of government. Kentucky, Nebraska, Nevada, New York, North Carolina, Ohio and Oregon cohosted Seminars which provided advocacy training for hundreds of physicians.

Conclusion

Your support for and interest in AMPAC's activities is most sincerely appreciated. All of us must recognize that we have a duty to our profession and our patients to assure that the interests of medicine are properly represented in the halls of Congress. AMPAC must maintain a strong voice in this important work.

RETIRING DELEGATES AND EXECUTIVES**Arizona**

William Mangold, MD

Illinois

Theodore M. Kanellakes, MD
Sandra F. Olson, MD
M. LeRoy Sprang, MD
William Werner, MD

Iowa

Carole Frier, DO

New Jersey

R. Gregory Sachs, MD

New York

Richard P. Stechel, MD

Ohio

J. Steven Polsley, MD

Pennsylvania

Juan P. Aparicio
Michael W. Best, MD
Alexis Chidi
Lauren Kramer
Brandi N. Ring, MD
C. Richard Schott, MD
Stephen L. Schwartz, MD
Sokpoleak So, MD

Texas

Robert B. Morrow, MD
David D. Teuscher, MD

Utah

William Hamilton, MD

Washington

Julie A. Komarow, MD

American Academy of Family Physicians

Ajoy Kumar, MD

American College of Nuclear Medicine

W. Marion Jordan, MD

American College of Radiology

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