

REPORTS OF REFERENCE COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES 2014 INTERIM MEETING

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

(1) BOARD OF TRUSTEES REPORT 9 - SPECIALTY SOCIETY
REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE YEAR
REVIEW

RECOMMENDATION:

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

**HOD ACTION: The recommendations in Board of Trustees Report 9 adopted
and the remainder of the report filed.**

Board of Trustees Report 9 recommends that the American College of Cardiology, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine and the American Medical Group Association retain representation in the American Medical Association House of Delegates. Board of Trustees Report 9 further recommends that the National Association of Medical Examiners be given a grace period of one year to meet the membership requirements to retain their position in the AMA House of Delegates, and that the American College of Chest Physicians be given six months to submit materials for consideration for continued representation in the AMA House of Delegates or risk loss of representation in the House of Delegates. Finally, Board of Trustees Report 9 recommends that the Society of Medical Consultants to the Armed Forces representation in the AMA House of Delegates be terminated per the organization's request.

The Board of Trustees introduced this report and there was no further testimony. Your Reference Committee recommends that Board of Trustees Report 9 be adopted.

(2) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 –
PHYSICIAN EXERCISE OF CONSCIENCE

RECOMMENDATION:

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

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

Council on Ethical and Judicial Affairs Report 1 examines the implications for patients, physicians and the medical profession when conflict arises between a physician's professional commitments and his or her deeply held personal moral beliefs. It offers guidance on when a physician's professional commitments should outweigh personal beliefs as well as when physicians should have freedom to act according to the dictates of conscience while still protecting patients' interests.

Testimony on this report was mixed. Some concern was heard regarding recommendation (f) which speaks about physicians offering impartial guidance when referral is not an option due to deeply held, well-considered personal beliefs. Concerns were also expressed that recommendation (f) stated that this recommendation does not consider that insurance plans often require referrals in order to cover payment for services. However, your Reference Committee believes that the issues of informing and patient referral have been adequately discussed in the body of

the report and that the report and recommendations, including (f), present a balanced and neutral approach to this difficult topic. Other objections to the report revolved around language of “illegal” discrimination versus “discrimination”. The rest of the testimony was either in favor of adopting the report or rehashing issues heard at previous reference committee hearings. Your Reference Committee believes that CEJA has addressed all the pertinent issues in the body of the report and in the recommendations themselves. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted.

(3) RESOLUTION 2 – PROTECTING MEDICAL STUDENTS’ RIGHTS AS PATIENTS

RECOMMENDATION:

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

HOD ACTION: Resolution 2 adopted

Resolution 2 asks that our AMA Policy H-315.983 “Patient Privacy and Confidentiality” be amended by insertion and deletion. Currently, Policy H-312.983 affirms that physicians as patients have the same right to privacy and confidentiality of personal medical information and medical records as all other patients, and Resolution 2 recommends adding “and medical students” where appropriate. The resolution cites a recent article in the *Journal of the American Medical Association* which discusses medical students as a unique demographic whose willingness to seek care to address mental health concerns is limited by fear of consequences to career opportunities and academic evaluations.

The majority of testimony favored this resolution and noted that medical students should have the same rights as all patients. Some testimony noted that current AMA policy addresses this issue, but your Reference Committee believes that this is sufficiently important to amend the policy noted in the resolution to ensure that medical students are protected as patients. Therefore your Reference Committee recommends that Resolution 2 be adopted.

(4) RESOLUTION 7 – DELEGATE COUNTS FOR RFS ASSEMBLY MEETINGS

RECOMMENDATION:

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

HOD ACTION: Resolution 7 adopted.

Resolution 7 asks that our AMA amend several provisions to the Bylaws concerning the Resident and Fellow Section. The resolution asks that Bylaw 7.1.3.2 be amended to allow resident/fellow physician representative to attend the Business Meeting even if a state medical society does not provide full membership. The resolution then asks that Bylaw 7.1.3.3 be modified to allow each Federal Service represented in the AMA House of Delegates to select one representative and one alternate representative for every 100, or fraction thereof, who are resident/fellow members, and eliminate the provision in Bylaw 7.1.3.4 requiring national medical societies who desire to participate in the Business Meeting of the Resident and Fellow Section to have established a resident/fellow physician membership component. Finally, Resolution 7 asks that our AMA modify Bylaw 7.1.3.5 to allow each professional interest medical association represented in the AMA House of Delegates to select one representative and one alternate representative for every 100, or fraction thereof, who are resident and fellow members.

Testimony in favor of this resolution spoke of how changes to the bylaws would offer greater support for residents and fellows, and that such a modification could help residents and fellows who have relocated to a new state for their programs to have an opportunity to stay involved in the AMA. Some testimony questioned how this resolution, if adopted, would operate in terms of resident/fellow representation and funding, while other testimony reflected confusion over how this resolution would work procedurally. Because this resolution would allow for greater

inclusiveness of resident and fellow members, your Reference Committee recommends that Resolution 7 be adopted.

(5) RESOLUTION 3 – SOLITARY CONFINEMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 3 be amended by addition and deletion on page 1, lines 23-24 to read as follows:

RESOLVED, That our American Medical Association oppose the use of solitary confinement ~~for juveniles or the mentally ill regardless of circumstance in juvenile correction facilities except for extraordinary circumstances such as the protection of the juvenile, staff, or other detainees when a juvenile is at acute risk of harm to self or others~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 3 be amended by addition on page 1, lines 26-27 to read as follows:

RESOLVED, That our AMA oppose the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities. (New HOD Policy); and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the third Resolve of Resolution 3 be amended by addition and deletion on page 1, lines 29-30 to read as follows:

RESOLVED, That our AMA support that isolation of juveniles for clinical or therapeutic purposes must be conducted under the ~~recommendation and~~ supervision of a physician. (Directive to Take Action)

RECOMMENDATION D:

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

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 3 be changed to read as follows:

SOLITARY CONFINEMENT OF JUVENILES IN LEGAL CUSTODY

HOD ACTION: Resolution 3 adopted as amended with a title change.

Resolution 3 asks that our AMA oppose the use of solitary confinement for juveniles or the mentally ill regardless of circumstance, and that the AMA oppose the use of solitary confinement for disciplinary purposes overall. Research on solitary confinement from both psychiatry and public health has demonstrated the dangerous and deleterious physical, emotional, and psychological consequences such punishment can impart on prisoners, especially those already struggling with mental illness. Thus, this resolution asks that our AMA only support the use of isolation

procedures intended for clinical or therapeutic purposes that must be conducted under the recommendation and supervision of a physician.

Testimony for this resolution was mixed. Those speaking in favor of the resolution discussed the dangerous outcomes that can happen when prisoners are subjected to solitary confinement, and that the usage of solitary confinement for punitive measures can exacerbate mental illness and physical health problems. A considerable amount of testimony in favor of the resolution recommended focusing solely on the use of solitary confinement for juveniles, and that the use of solitary confinement in this specific population is clearly abhorrent while its use in adult populations delves into much more complicated issues that cannot be addressed by the resolution. Those in favor of the use of solitary confinement for adult populations discussed how it can serve a role protecting the health and safety of prisoners, patients, and the public in situations where dangerous individuals must be separated from the general population in particular contexts. Testimony against the resolution also highlighted the complexity of the topic of solitary confinement, and that, as it stands, the resolution is too unclear in its current form and fails to appreciate that many layers and challenges this subject presents. Based on the testimony heard, your Reference Committee recommends that the language in Resolution 3 be amended to focus on juvenile populations, and that Resolution 3 be adopted as amended.

(6) RESOLUTION 4 – LEGAL PROTECTION AND SOCIAL SERVICES FOR COMMERCIALIALLY SEXUALLY EXPLOITED YOUTH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 4 be amended by addition and deletion on page 1, lines 21-26 to read as follows:

RESOLVED, That our American Medical Association work with state medical societies and specialty societies to 1) where appropriate, advocate for legal protection and alternatives to incarceration for commercially sexually exploited youth as an alternative to prosecution for crimes related to their sexual or criminal exploitation, and 2) encourage the development of appropriate, and comprehensive, trauma informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth. (Directive to Take Action)

RECOMMENDATION B:

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

HOD ACTION: Resolution 4 adopted as amended.

Resolution 4 describes that as Commercial Sexual Exploitation of Children (CSEC) becomes a larger problem in the US, several groups (twelve states and the Institution of Medicine) have taken steps to protect children as victims as opposed to criminals. In light of this appropriately changing landscape, Resolution 4 asks that our AMA work with state medical societies to advocate for legal protection for commercially sexually exploited youth as an alternative to prosecution for crimes related to sexual exploitation. Resolution 4 also asks that our AMA encourage the development of appropriate, comprehensive, trauma-informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth.

The testimony for this resolution spoke largely in favor of adoption. Those speaking in support of this resolution noted how the children and adolescents who fall victim to sexual and criminal exploitation constitute a vulnerable population that require greater protections from further harms. Some testimony noted that the language of the resolution may be too broad and could be interpreted to offer blanket protections for minors who are criminally culpable or dangerous to the public. Limited testimony against the resolution stated that the topic of greater legal protections and social services for commercially sexually exploited youth may be too complex of an issue to be

addressed in a resolution, and that a more cogent policy may be needed to appropriately address this topic. Your Reference Committee recommends that Resolution 4 be adopted as amended.

(7) RESOLUTION 6 – PHYSICIAN RIGHT TO CONSCIENCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 6 be adopted:

PHYSICIAN CIVIL DISCOURSE

RESOLVED, That our American Medical Association support high standards of civility and respect among physicians amidst differing political beliefs, aspects of conscience and ethical views because debate and expression of disagreement is healthy and essential to the improvement of medicine, and physicians should communicate any differences in a civil and professional manner. (New HOD Policy)

HOD ACTION: Substitute Resolution 6 adopted.

Resolution 6 asks that our AMA support high standards of civility and respect among physicians amidst differing political beliefs, conscience and ethics. Resolution 6 also asks that our AMA develop policy that debate and expression of disagreement are essential to the improvement of medicine, and physicians should communicate any differences in a civil and professional manner. The Resolution recommends that the HOD request the Council on Ethical and Judicial Affairs to consider this topic for inclusion in the *Code of Medical Ethics*.

Testimony on this resolution reflected confusion as to what the resolution was actually addressing given the Council on Ethical and Judicial Affairs report being presented with the same title. Therefore, considerable testimony called for a clarification about the subject matter of the resolution. Once it was made clear that the subject of the resolution was about civil discourse amongst physicians, testimony predominately spoke in favor of the resolution's support. In order to more accurately reflect the topic of the resolution, your Reference Committee recommends that the title be changed and the resolutions amended, and that Resolution 6 be adopted as amended.

(8) RESOLUTION 8 – ENSURING ACCESS TO HEALTH CARE, MENTAL
HEALTH CARE, LEGAL AND SOCIAL SERVICES FOR
UNACCOMPANIED MINORS AND OTHER RECENTLY MIGRATED
CHILDREN AND YOUTH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 8 be amended by addition and deletion on page 1, lines 17-21 to read as follows:

RESOLVED, That our American Medical Association encourage work with ~~state and local~~ medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure ~~federal, state, and other funding sources to support those services, including~~ ~~health care and mental health, legal, education, and social services.~~ (New HOD Policy)

RECOMMENDATION B:

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

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 8 be changed to read as follows:

ENSURING ACCESS TO HEALTH CARE, MENTAL HEALTH CARE,
LEGAL AND SOCIAL SERVICES FOR UNACCOMPANIED MINORS AND
OTHER RECENTLY IMMIGRATED CHILDREN AND YOUTH

HOD ACTION: Resolution 8 adopted as amended with a title change.

The past year has shown a significant increase in the number of immigrant children migrating to the US across the Southwestern border. Many of these children have experienced traumatic events and require various social services, including medical services. Resolution 8 asks that our AMA encourage state and local medical societies and all clinicians to work together with other child serving sectors to ensure that new immigrant children receive timely and age appropriate services that support their health and well-being, including health care and mental health, legal, education, and social services.

Testimony regarding this resolution was equally divided. While there was general agreement that this was a timely and critically important issue given the tens of thousands of unaccompanied illegal immigrant minors desperately in need of medical care and services, divisions in opinion stemmed from how to best approach this dilemma. Those speaking in favor of the resolution discussed how immigrant children in the United States require immediate care regardless of strained resources and uncertain social and legal realities, while testimony against the resolution highlighted the considerable financial resources that are required to adequately address this growing medical need. Calls for referral of the resolution focused on the failure of the federal government to financially support efforts to aid in the provision of care, and that states and local communities have been left to shoulder the burden these vulnerable minors present. Therefore, your Reference Committee recommends that Resolution 8 be adopted as amended.

(9) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 –
PRESCRIBING AND DISPENSING SAMPLE MEDICATIONS

RECOMMENDATION:

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

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

Council on Ethical and Judicial Affairs Report 2 examines the benefits and challenges of prescribing and dispensing sample medications. The report offers guidance to physicians regarding responsible practice when prescribing and dispensing sample medications in order to maximize benefits for patients and minimize risks.

Testimony regarding this report favored referral. Much of the testimony centered on the resources needed to comply with the requirements set forth in the recommendations, and that these recommendations are too burdensome on physician practice. Other testimony focused on the thought that the recommendations seem to be practice guidelines rather than ethical guidance. Because this is a complex issue and many concerns were heard, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

(10) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 –
MODERNIZED CODE OF MEDICAL ETHICS

RECOMMENDATION:

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

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

Council on Ethical and Judicial Affairs Report 3 recommends that the individual Opinions contained in the 2014-2015 edition of the AMA *Code of Medical Ethics* be amended by substitution with proposed new Opinions. The Council on Ethical and Judicial Affairs has been working on the updated *Code* since 2008, and this report presents that body of work.

Your Reference Committee heard this item in chapter order, with time for general comments about the report heard at the end. Particular edits and concerns were heard for chapters 2A and 2B, no concerns heard for chapters 3, 4, 6, 8 or 10, and minimal comments heard for chapters 5, 7, 9 and 11. While much of the testimony commended the Council on Ethical and Judicial Affairs for taking on the task of updating the *Code of Medical Ethics*, the comments, concerns and edits heard were significant enough to warrant CEJA reviewing the updated *Code* with this testimony in mind. Much of the testimony also asked that the documents continue to be available for comment online in the months to come. With CEJA's agreement, the document will remain posted through midnight on December 31, 2014. CEJA will then review all feedback received at this meeting and online and revise the document accordingly. CEJA will post the revisions as soon as they are available and with significant time to review the document before A-15. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

(11) RESOLUTION 1 – ADVANCE DIRECTIVES DURING PREGNANCY

RECOMMENDATION:

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

HOD ACTION: Resolution 1 referred.

Resolution 1 asks that our AMA support that pregnant women with decision-making capacity have the same right to refusal of treatment through advance directives as nonpregnant women. While a small minority of states allow pregnant women to refuse life-sustaining treatment, a majority of states forbid all pregnant patients or pregnant patients with potentially viable pregnancies from executing their decisions to withhold or withdraw life-sustaining care. This resolution asks that our AMA further study the legal and ethical facets of situations under which restrictions, exclusions, or both are applied to the advance directives of pregnant women.

Testimony for this resolution supported the resolve that our AMA undertake a study of the legal and ethical issues that arise when a pregnant patient chooses to withhold or withdraw life sustaining treatment via advance directive. Further, while testimony spoke in favor of pursuing this investigation, it cautioned the adoption of the resolution's first resolve. This resolve called for the AMA to support the decision-making capacity of pregnant women and their right to refuse treatment through advance directives, before the initial research asked in the second resolve has been conducted. Your Reference Committee believes that this is an extremely complex issue that warrants further study in light of the ethical and legal issues contained therein. Therefore, your Reference Committee recommends that Resolution 1 be referred.

(12) RESOLUTION 9 – THE AMA MUST SUPPORT HEALTH CARE FOR ALL,
REGARDLESS OF AGE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 9 not be adopted.

HOD ACTION: Resolution 9 not adopted.

Resolution 9 asks that our AMA issue a statement publicly disagreeing with the sentiments by Dr. Ezekiel Emanuel in his September 2014 *Atlantic* article, and that the AMA should cite the Code of Medical Ethics as the basis for disagreement. The resolution states that in particular, Principles I, VIII and IX should serve as the basis for this admonishment. The resolution also asks that the AMA urge the AMA Foundation to rescind the Isaac Hays, MD and James Bell, MD Award for Leadership in Medical Ethics and Professionalism award bestowed on Dr. Emanuel in light of this article. Finally, Resolution 9 asks that the AMA urge the AMA Foundation to make clear to all award recipients that bestowing of an award does not mean that our AMA endorses every position espoused by the award recipient.

Testimony largely supported not adoption of this resolution. Many of those who testified clarified the point that Dr. Emanuel was speaking about himself in his article, and not patients in general. They noted that Dr. Emanuel is entitled to make his own decisions about health care, as all patients are. Further, rescinding an award given to him by the AMA Foundation would cause undue controversy, particularly as the article in question does not relate to the award received. Your Reference Committee did hear discussion surrounding the issues of end of life care, elder care and patient autonomy. However, these are not pertinent to the aim of this resolution although we recognize the importance of having a broader discussion around these issues in the future. Therefore, your Reference Committee recommends that Resolution 9 be not adopted.

REPORT OF REFERENCE COMMITTEE B

(1) RESOLUTION 204 – ICD-10 AND COST OF CODING CHANGES

RECOMMENDATION:

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

HOD ACTION: Resolution 204 adopted.

Resolution 204 asks that our American Medical Association work toward the goal of having insurance companies and governmental entities reimburse physicians for the extra cost of increasingly complex and mandatory changes in coding. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 204. Testimony strongly voiced that our AMA should continue to prioritize our existing AMA policy that first seeks to stop the implementation of the ICD-10 code set. Others noted that, if implemented, ICD-10 coding will create unnecessary and significant financial and workflow disruptions for physicians that should be mitigated. In particular, this testimony stated that the vast increase in the number of ICD-10 codes compared to ICD-9 will require physicians to install new billing systems, train staff, and incur other related expenses. Your Reference Committee notes that our AMA has studied the estimated costs of ICD-10 implementation and found large financial investments for both small and large practices. Based on this significant potential expense, your Reference Committee agrees that our AMA should seek to mitigate these costs if the code set is implemented, and recommends that Resolution 204 be adopted.

(2) RESOLUTION 217 – POWDERED CAFFEINE AND EASY UNINTENTIONAL OVERDOSE

RECOMMENDATION:

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

HOD ACTION: Resolution 217 adopted.

Resolution 217 asks that our American Medical Association seek regulation or legislation to ban the sale of powdered caffeine to minors (Directive to Take Action); and that our AMA issue a statement condemning the sale of powdered caffeine in packaging so concentrated, so difficult to measure, and in sufficient quantity that misuse and overdose is too common. (Directive to Take Action)

Your Reference Committee heard limited but strongly supportive testimony related to Resolution 217. Testimony was presented about the dangers of powdered caffeine, which is sold mostly over the internet and is used by some teenagers to boost workouts, weight loss, and energy. Additional testimony was offered that the powder is so concentrated that it is easy to overdose. One serving is just a sixteenth of a teaspoon, an amount so small it is nearly impossible to measure and, according to the US Food and Drug Administration, a teaspoon of powdered caffeine is roughly equal to the amount in 25 cups of coffee. Your Reference Committee heard that powdered caffeine has been implicated in more than two dozen recent illnesses and two deaths of high school students. Your Reference Committee agrees with this testimony and recommends adoption of Resolution 217.

(3) RESOLUTION 225 – PHYSICIAN CREDIT CARD PAYMENTS BY
HEALTH INSURANCE COMPANIES

RECOMMENDATION:

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

HOD ACTION: Resolution 225 adopted.

Resolution 225 asks that our American Medical Association consider legislation on behalf of physicians that any credit card transaction/bank fees are paid by the insurer and not the health care provider. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 225. Testimony outlined the high transaction fees physicians incur when using virtual credit cards and that many physicians are unaware of this additional charge. Those testifying also highlighted the extensive AMA advocacy on this issue, including model state legislation that seeks to limit this practice. Based on this testimony, your Reference Committee recommends that Resolution 225 be adopted.

(4) BOARD OF TRUSTEES REPORT 5 – FDA REGULATION OF OFF-LABEL
DRUG PROMOTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that recommendation 1 of the Board of Trustees Report 5 be amended by addition and deletion to read as follows:

(1) The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label unlabeled indication when such use is based upon sound scientific evidence and or sound expert medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate “off-label” uses of drugs on their formulary.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations of the Board of Trustees Report 5, amending Policy H-120.988, be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Board of Trustees Report 5, amending Policy H-120.988,
adopted as amended and the remainder of the report filed.**

The Board of Trustees recommends:

1. That Policy H-120.988 be amended by addition and deletion to read as follows:

H-120.988 Patient Access to Treatments Prescribed by Their Physicians

(1) The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label unlabeled indication when such use is based upon sound scientific evidence and or sound expert medical

opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate “off-label” uses of drugs on their formulary.

~~The AMA recommends the following: Prescribing and Reimbursement for FDA Approved Drugs and Devices for Unlabeled Uses~~

~~(1) Our AMA reaffirms the following policies:~~

- ~~(a) A physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion (Policy H-120.988);~~
- ~~(b) When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy (Policy H-120.988); and~~
- ~~(c) Our AMA encourages the use of three compendia (AMA's Drug Evaluations*; United States Pharmacopeia Drug Information, Volume I*; and American Hospital Formulary Service Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses (Policy H-165.896, #15).~~
- ~~(*These two compendia currently are being merged as the result of an alliance between the American Medical Association and the United States Pharmacopeia.) Dissemination of Information about Unlabeled Uses of Drugs and Devices by Manufacturers~~

~~(2) Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label unlabeled uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.~~

~~(3) Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, and scientifically sound, information and truthful and not misleading, about unlabeled uses by manufacturers to physicians, if the independent information should be is provided in its entirety, is not be edited or altered by the manufacturer, and be is clearly distinguished and not appended to from manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label unlabeled uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. Can be supported under the following conditions:~~

- ~~(a) Reprints of independently derived articles from reputable, peer reviewed journals that meet the following criteria:~~
- ~~(i) The article should be peer reviewed and published in accordance with the regular peer review procedure of the journal in which it is published;~~
- ~~(ii) The reprint should be from a peer-reviewed journal that both has an editorial board and utilizes experts to review and objectively select, reject, or provide comments about proposed articles; such experts should have demonstrated expertise in the subject of the article under review, and be independent from the journal;~~
- ~~(iii) The journal is recognized to be of national scope and reputation, as defined by an advisory panel to the FDA; among its members, this advisory panel should have representatives from national medical societies;~~
- ~~(iv) The journal must be indexed in the Index Medicus of the National Library of Medicine;~~
- ~~(v) The journal must have and adhere to a publicly stated policy of full disclosure of any conflicts of interest or biases for all authors or contributors;~~
- ~~(vi) When the subject of the article is an unlabeled use, or the article contains other information that is different from approved labeling, the industry sponsor disseminating the reprint must disclose that the reprint includes information that has not been approved by the FDA and attach a copy of the FDA approved professional labeling with the reprint;~~
- ~~(vii) If financial support for the study and/or the author(s) was provided by the industry sponsor disseminating the article, and this is not already stated in the article, then this information should be clearly disclosed with the reprint.~~

(b) Reprints of monographs or chapters from the three compendia (AMA's Drug Evaluations; United States Pharmacopeia Drug Information, Volume I; and American Hospital Formulary Service Drug Information) named in federal statutes for determining the medical acceptability of unlabeled uses, provided:

- (i) The monograph or chapter is reprinted in its entirety by the publisher of the compendia, and the reprints are then sent to the requesting industry sponsor;
- (ii) The reprints are not altered in any way by the industry sponsor;
- (iii) The industry sponsor disseminating the reprint discloses that the reprint includes information that has not been approved by the FDA and attaches a copy of the FDA approved professional labeling with the reprint.

(c) Complete textbooks that meet the following criteria:

- (i) The reference text should not have been written, edited, excerpted, or published specifically for, or at the request of, a drug, device, or biologic firm; when financial support is provided by a drug, device, or biologic firm, it should be disclosed clearly in the textbook;
- (ii) The content of the reference text should not have been edited or significantly influenced by a drug, device, or biologic firm, or agent thereof;
- (iii) The reference text should be generally available for sale in bookstores or other distribution channels where similar books are normally available and should not be distributed only or primarily through drug, device, or biologic firms;
- (iv) The reference text should not focus primarily on any particular drug(s), device(s), or biologic(s) of the disseminating company, nor should it have a significant focus on unapproved uses of drug(s), device(s), or biologic(s) marketed or under investigation by the firm supporting the dissemination of the text;
- (v) Specific product information (other than the approved package insert) should not be physically appended to the reference text.

(d) Manufacturers should report to the FDA and share with all physicians any proprietary information that a drug is ineffective or unsafe when used for a specific unlabeled indication.

(e) Continuing medical education (CME) activities:

- (i) The FDA should continue to support principles in the FDA Draft Policy Statement on Industry Supported Scientific and Educational Activities (Fed. Reg. 1992;57:56412-56414), which acknowledges the importance of relying on the professional health care communities, rather than the Agency, to monitor independent provider activities, and
- (ii) The FDA should continue a policy of regulatory deference for industry supported CME activities conducted by organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME), state medical societies, specialty societies, and the American Academy of Family Physicians (AAFP), that follow the Essentials and Standards of the ACCME and that may be certified for AMA PRA credit under the auspices of the American Medical Association Physician's Recognition Award program.

(4) Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an unlabeled off-label use).

Improving the Supplemental New Drug Application (SNDAs) Process

(5) Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

(6) Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act
(Modify Current HOD Policy)

(6) Our AMA encourages the US Congress, the FDA, pharmaceutical manufacturers, the United States Pharmacopeia, patient organizations, and medical specialty societies to work together to ensure that Supplemental New Drug Applications (SNDAs) for new indications (efficacy supplements), including those for uses in special populations (e.g., pediatrics), are submitted and acted upon in a timely manner. Specific recommendations include:

- (a) ~~User fee legislation should be re-authorized to ensure that the FDA has the necessary resources to act on all efficacy supplements within 6 months of submission;~~
- (b) ~~The SNDA process should be streamlined as much as possible (e.g., basing review decisions on already published literature), without compromising the requirements for substantial evidence of efficacy and safety;~~
- (c) ~~Legislation should be enacted that provides extensions of marketing exclusivity for the product to manufacturers who submit and gain FDA approval of efficacy supplements, including mechanisms both to provide greater reward when the new indication is for a life threatening disease (with limited or no alternatives), an orphan disease, or for a special population (e.g., pediatrics), and to prevent inappropriate use of the system by manufacturers (e.g., place a limit on total length of extended marketing exclusivity);~~
- (d) ~~For drugs no longer under patent and for which generic versions are available, the FDA, other governmental agencies (e.g., the National Institutes of Health), the pharmaceutical industry, the United States Pharmacopeia, patient organizations, and medical specialty societies should discuss and mutually agree on alternative mechanisms to ensure that efficacy supplements will be submitted to and acted upon by the FDA in a timely manner; and~~
- (e) ~~Pharmaceutical manufacturers are urged to seek FDA approval for pediatric uses through the FDA's 1994 regulation that allows approval of pediatric uses based on adult efficacy studies (where the course of the disease and the effects of the drug are sufficiently similar in both populations) and additional information for pediatric use, usually pharmacokinetic studies for determination of dosage (Fed. Reg. 1994:59:64240-64250).~~

Encouraging Clinical Research in Pediatrics

- (7) ~~Our AMA urges pharmaceutical manufacturers and the FDA to work with the American Academy of Pediatrics and experts in pediatric medicine to identify those investigational drugs that would have pediatric indications and set up a mechanism to ensure that necessary pediatric clinical studies are completed prior to submission of NDAs for approval of these drug products. Legislation should be enacted that provides extensions of marketing exclusivity for the product to manufacturers who complete pediatric studies that lead to pediatric labeling (Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10) (Modify Current HOD Policy)~~

2. Policy H-60.933, Reauthorization of BPCA and PREA be rescinded. (Rescind HOD Policy)

Your Reference Committee heard testimony generally in support of Board of Trustees Report 5. This testimony highlighted the importance to physicians and patients of medically accepted off-label uses. Those in support of the report agreed strongly that physicians should have access to truthful and non-misleading information about unapproved uses of medicines. Testimony from a representative of the Pharmaceutical Research and Manufacturers of America (PhRMA) noted that, while they agreed with several aspects of the report, they worried that its recommendations may still limit the ability of companies to provide information to patients about medically accepted off-label uses and offered an amendment. Other testimony noted that the author of the report was aware of the concerns raised by PhRMA and drafted the report to balance the need to access information while ensuring such content is not presented out of context. Additional amendments were offered to include an ask that our AMA support federally funded clinical trials to help ensure that the source of off-label information is not limited to industry information and that the report amend references to reasonable and necessary medical care and expert medical opinion in section 1 to ensure clarity.

Your Reference Committee agrees that the report appropriately considers and addresses the concerns raised by off-label promotion and balances the need for such information to be truthful and not misleading. Your Reference Committee also agrees with the clarifying amendments. With respect to the ask on funding for clinical research, we believe that existing AMA policy H-460.926 already covers this goal, asking that our AMA support ample federal funding for medical research, including clinical research and clinical trials. Therefore, your Reference Committee recommends that the recommendations of Board of Trustees Report 5 be amended and that the remainder of the report be filed.

(5) RESOLUTION 202 – SOBRIETY CHECKPOINTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 202 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support the use of legal and constitutional sobriety checkpoints to deter driving following alcohol consumption (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 202 be amended by addition to read as follows:

RESOLVED, that our AMA work with interested state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints.

RECOMMENDATION C:

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

HOD ACTION: Resolution 202 adopted as amended.

Resolution 202 asks that our American Medical Association support the use of sobriety checkpoints to deter driving following alcohol consumption (New HOD Policy); and that our AMA work with state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of Resolution 202. The goal of this resolution is consistent with AMA policies that support state and federal legislative efforts to prevent alcohol-impaired driving and strengthen impaired driving laws and their enforcement. Your Reference Committee believes that AMA support of legal and constitutional sobriety checkpoints to deter drunk driving, and advocacy with interested state medical societies to overturn legislative bans on the use of sobriety checkpoints, are consistent with existing AMA policy. Your Reference Committee, therefore, recommends that Resolution 202 be adopted as amended.

(6) RESOLUTION 205 – JUVENILE JUSTICE SYSTEM REFORM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first and third Resolves of Resolution 205 be amended by deletion.

RESOLVED, That our American Medical Association advocate for the Department of Justice to work towards the elimination of the school-to-jail pipeline which disproportionately affects African American youth (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the Department of Housing and Urban Development to reconsider banning non-violent juvenile offenders from public housing thereby preventing a minor child from returning to their family. (Directive to Take Action)

RECOMMENDATION B:

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

RESOLVED, That our American Medical Association strongly support policy AMA lobby the US Department of Health and Human Services and the Department of Justice to ensure that youth incarcerated in short-term and long-term correctional facilities receive medical and mental health care consistent with community standards age-appropriate recommendations in order to improve their health outcomes (Directive to Take Action);

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 205 be adopted as amended.

HOD ACTION: Resolution 205 referred.

Resolution 205 asks that our American Medical Association advocate for the Department of Justice to work towards the elimination of the school to jail pipeline which disproportionately affects African American youth (Directive to Take Action); and that our AMA lobby the US Department of Health and Human Services and the Department of Justice to ensure that youth incarcerated in short-term and long-term correctional facilities receive medical and mental health care consistent with community standards in order to improve their health outcomes (Directive to Take Action); and that our AMA advocate for the Department of Housing and Urban Development to reconsider banning non-violent juvenile offenders from public housing thereby preventing a minor child from returning to their family. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 205. Testimony in support of the resolution focused on the need to reform the juvenile justice system in order to improve health outcomes for African-American youth and other minorities. However, testimony was also presented that Resolves 1 and 3 of the resolution, calling on our AMA to advocate for the US Department of Justice (DOJ) to work towards the elimination of the school to jail pipeline, and to advocate for the US Department of Housing and Urban Development to reconsider banning non-violent juvenile offenders from public housing, go beyond the mission and current focus of our AMA. In addition, it was noted in testimony that there are numerous organizations that focus specifically on advocacy related to child welfare and juvenile justice reform. Other testimony sought a clarifying amendment to address the reference to community standards.

Based on this testimony, your Reference Committee agrees that Resolves 1 and 3 are generally outside the mission of our AMA and would detract from our current strategic focus, but agrees that Resolve 2 addresses an important health concern that should be part of our AMA advocacy. Specifically, your Reference Committee believes that in addition to lobbying efforts targeted at specific agencies our AMA should generally advocate for these important health improvements for incarcerated youth. Your Reference Committee also agrees with the amendment to include age appropriate recommendations, although without reference to a specific society or specialty group, as opposed to community standards. Therefore, your Reference Committee recommends that Resolution 205 be amended to reflect this broader advocacy.

(7) RESOLUTION 207 – GENERIC PHARMACEUTICAL PRICING
 RESOLUTION 228 – HIGH COST OF DRUGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 207 be adopted in lieu of Resolutions 207 and 228.

RESOLVED, That our American Medical Association make physicians aware of practices by manufacturers to force switching of brand formulations of prescription drugs (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the US Food and Drug Administration (FDA) and Congress ascertain the pervasiveness of forced switching and advance solutions that strike an appropriate balance between incentives and competition in order to support patient access to the newest treatments as well as those that are cost-effective.

HOD ACTION: Resolutions 207 and 228 referred.

Resolution 207 asks that our American Medical Association advocate for prescription drug cost containment, and communicate concerns about the rapidly rising cost of generic prescription drugs to the US Food and Drug Administration. (Directive to Take Action) Resolution 228 states that our AMA advocate for a comprehensive federal government (e.g., CMS, etc.) study of the development and pricing practices of the pharmaceutical industry and inform the Congress of the United States if any questionable pricing practices are discovered (Directive to Take Action); and that our AMA explore the rapidly escalating cost of generic drugs that are years past developmental costs (Directive to Take Action); and that our AMA report back to the House of Delegates at A-15 (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning Resolutions 207 and 228. Testimony noted that the FDA does not have a role in containing the cost of prescription drugs, but is charged with evaluating the safety and efficacy of generic and brand drugs. This Testimony also noted that Resolution 207 was already generally covered by existing AMA policy. Testimony noted that Resolution 219 from the 2014 Annual Meeting raised similar concerns about practices by manufacturers to force switching to more expensive products in order to maintain their market share, and was referred to the Board of Trustees for decision. The Board of Trustees acted by adopting new policy that asks our AMA to (1) raise awareness among physicians of the strategy that could be used to limit the value to manufacturers of forced switching of brand formulations of prescription drugs; and (2) advocate that the FDA and Congress ascertain the pervasiveness of this practice and advance solutions that strike an appropriate balance between innovation incentives and competition in order to support patient access to the newest treatments as well as those that are cost-effective. Our AMA has thus recently considered practices by manufacturers to force switching to more expensive products in order to maintain their market share.

Your Reference Committee believes that there is an ongoing need to ensure that manufacturers of drugs are not engaging in forced switching, and the best strategy is to engage with a broad cross-section of stakeholders to assess the scope of this problem and identify both self-help strategies as well as policy modifications, as needed. Your Reference Committee therefore recommends that Substitute Resolution 207 be adopted in lieu of Resolutions 207 and 228, which follows the language that was adopted by our Board of Trustees.

(8) RESOLUTION 208 – STARK LAW AND PHYSICIAN COMPENSATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 208 be amended by addition and deletion to read as follows:

That our American Medical Association ~~opposes the use of the Stark law support repeal of the Stark Law and regulations or their revision such that they cannot be used by employers~~ to unfairly and arbitrarily cap or control physician compensation. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 referred.

Resolution 208 asks that our American Medical Association support repeal of the Stark Law and regulations or their revision such that they cannot be used by employers to unfairly and arbitrarily cap or control physician compensation. (Directive to Take Action)

Testimony heard by your Reference Committee on Resolution 208 was varied. Testimony emphasized some concern that the threat of Stark Law violations could have a negative impact on physician compensation arrangements. Testimony also stated that, while agreeing with the goals of this resolution, the call for legislative or regulatory changes may not be possible given the strong focus of lawmakers and regulators on fraud and abuse. This testimony also noted that our AMA should use all advocacy levers, beyond regulatory and legislative changes, to achieve the intent of this resolution. Those testifying also noted that our AMA may wish to further study this issue and suggested referral to investigate factors driving physician compensation at less than the fair market value. Your Reference Committee recognizes the concerns identified in this resolution and by those testifying and recommends that Resolution 208 be amended. This amendment would reflect suggested changes to use all available advocacy tools to oppose unfair caps or reductions imposed on physician compensation due to the Stark Law. Your Reference Committee believes this change will ensure our AMA can use its broad advocacy resources to address the goals of this resolution and therefore recommends that Resolution 208 be adopted as amended.

(9) RESOLUTION 210 – AMA PROMOTION OF IMPROVED ELECTRONIC HEALTH RECORDS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association continue to advocate or legislate that, within existing AMA policies, the Centers for Medicare & Medicaid Services (CMS) will suspend penalties to physicians and health care facilities for failure to meet Meaningful Use (MU) criteria, until such time as

1. All certified Electronic Health Records (EHRs) are fully interoperable,
2. A group of practicing physicians is appointed by CMS, after consultation with organized medicine, to review and advise CMS on the clinical relevance of all new requirements for EHRs and/or MU,
3. Any new elements for EHRs and/or MU required by CMS will be provided to physicians, health care facilities, and the EHR industry without charge,
4. All data generated on EHRs by physicians or at health care facilities are the property of those generating said data, and that EHRs ensure appropriate access rights for patients and other relevant parties.

(Directive to Take Action)

RECOMMENDATION B:

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

HOD ACTION: Resolution 210 adopted as amended.

Resolution 210 asks that our American Medical Association advocate or legislate that, within existing AMA policies, the Centers for Medicare & Medicaid Services (CMS) will suspend penalties to physicians and health care facilities for failure to meet Meaningful Use (MU) criteria until such time as: (1) All certified Electronic Health Records (EHRs) are fully interoperable, (2) A group of practicing physicians is appointed by CMS, after

consultation with Organized Medicine, to review and advise CMS on the clinical relevance of all new requirements for EHRs and/or MU, (3) Any new elements for EHRs and/or MU required by CMS will be provided to physicians, health care facilities, and the EHR industry without charge, (4) All data generated on EHRs by physicians or at health care facilities are the property of those generating said data. (Directive to Take Action)

Testimony received by your Reference Committee was supportive of Resolution 210. Many emphasized that the MU program remains a significant cost and disruption to physician practices, and that EHRs are not yet capable of exchanging health care information across different systems. Testimony also sought a change to this resolution to clarify that data ownership policies do not conflict with patient rights to access their health information, and that we support specific hardship exemptions for certain specialties. Your Reference Committee agrees with the testimony and recognizes the extensive AMA policy and advocacy that addresses EHRs and the MU program. Specifically, existing AMA policy and advocacy already cover most of the points outlined in this resolution, including the amendment offered to expand hardship exemptions to certain specialties. Specifically, our AMA recently submitted to CMS a comprehensive blueprint for the MU program that incorporates this request as well as many others to improve program flexibility. To reflect this work, your Reference Committee suggests that the resolution be amended to state that the AMA will continue its advocacy on this issue and delete the reference to legislation since only Congress, and not the AMA, can pass new laws. We also agree with the suggestion to ensure access to patient health information and believe that the fourth point should be amended to reflect these concerns. With these changes, your Reference Committee recommends that Resolution 210 be adopted as amended.

(10) RESOLUTION 211 – CPR TRAINING
 RESOLUTION 212 – CPR TRAINING AS A HIGH SCHOOL
 GRADUATION REQUIREMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 211 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support legislation that would request encourage high school students be trained in cardiopulmonary resuscitation. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 211 be adopted as amended in lieu of Resolution 212.

HOD ACTION: Resolution 211 adopted as amended in lieu of Resolution 212.

Resolution 211 asks that our American Medical Association support legislation that would request high school students be trained in cardiopulmonary resuscitation. (New HOD Policy) Resolution 212 asks that our AMA develop model state legislation and advocate that all states and the District of Columbia enact laws requiring high school students to pass a course in CPR as a graduation requirement. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 211. Testimony was offered as to the benefits of bystander CPR, and highlighted existing AMA policy that supports the incorporation of CPR classes as a voluntary part of secondary school programs. Your Reference Committee heard conflicting testimony on Resolution 212. Much of this testimony questioned whether laws requiring high school students to pass a course in CPR as a graduation requirement would produce unintended consequences, such as undue burdens for certain students, or for school districts that may lack the resources to effectuate such a mandate. Your Reference Committee clearly heard that CPR training in secondary school programs can save lives and should be encouraged, if not mandated. Therefore, your Reference Committee recommends that Resolution 211 be adopted as amended in lieu of Resolution 212.

(11) RESOLUTION 215 – PREAUTHORIZATION
 RESOLUTION 219 – OPPOSITION TO INSURANCE COMPANY POLICIES
 THAT INTERFERE WITH APPROPRIATE OUTPATIENT LABORATORY
 SERVICES
 RESOLUTION 221 – REMOVING BARRIERS TO PAYMENTS FOR
 VACCINE AND MEDICATION ADMINISTRATION
 RESOLUTION 222 – QUANTIFYING THE BURDEN OF PRIOR
 AUTHORIZATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 215 be adopted in lieu of Resolutions 215, 219, 221, and 222.

RESOLVED, That our American Medical Association reaffirm existing policy H-320.950, which seeks to mitigate the burden of preauthorization and other utilization review efforts; and be it further

RESOLVED, That our AMA ~~seek to~~ conduct a study to quantify the amount of time physicians and their staff spend on nonclinical administrative tasks, to include (1) authorizations and preauthorizations and (2) denial of authorization appeals.

RESOLVED, That there be a report back to the House of Delegates at A-15.

RESOLVED, That our AMA will utilize its advocacy resources to combat insurance company policies that interfere with appropriate laboratory testing by requiring advance notification or prior authorization of outpatient laboratory services.

HOD ACTION: Substitute Resolution 215 adopted as amended.

Resolution 215 asks that our American Medical Association convene a task force to study the effects of current preauthorization practices by managed care organizations (MCOs) on the reasonable access to care by patients as well as evaluating the effects of preauthorization on physicians practices and consider possible actions by the AMA and/or other members of the Federation to address the undesirable impact of intrusive preauthorization policies by MCOs (Directive to Take Action); and that our AMA develop model state legislation to limit the use of preauthorization by managed care in a way that promotes the safe, sound practice of medicine while promoting the goals of the Triple Aim (Direction to Take Action); and that our AMA work toward the creation and adoption of legislation that would limit the use of preauthorization by Medicare and Medicaid to those physicians who have been shown to be statistical outliers. (Direction to Take Action) Resolution 219 asks that our American Medical Association utilize its state-level resources and partnerships to combat insurance company policies that interfere with appropriate laboratory testing by requiring advance notification or prior authorization of outpatient laboratory services. (Directive to Take Action) Resolution 221 asks that our American Medical Association work with insurers to provide payments to physicians and physician-supervised designees for medications, vaccines and their administration without the burden of prior-authorization or any other administrative barriers. (Directive to Take Action) Resolution 222 asks that our American Medical Association conduct a survey to ascertain the extent of actual work beyond face-to-face time (including time and level of expertise) ostensibly covered by the relative values of commonly utilized Current Procedural Terminology (CPT) codes encountered in the course of providing health care services, specifically those of routine office management, and inclusive of (1) authorizations and pre-authorizations and (2) denial of authorizations appeal. Survey results should be available by the 2015 Interim Meeting. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of Resolutions 215, 219, 221, and 222. This testimony highlighted the administrative burden of prior authorization, the interruptions in patient care, the lack of reimbursement for the time required to manage these requests, and what was referred to as “rationing by

inconvenience." Testimony specifically highlighted the practices of managed care organizations requiring utilization review tools for certain laboratory tests and prior authorization in the context of vaccines and other injections. Those testifying, however, noted that many of the requests included in these resolutions are already covered by existing AMA advocacy and policy. Specifically, our AMA has already drafted model state legislation that aims to reduce the administrative burden and increase insurer transparency in the prior authorization process. In addition, testimony noted our Physician Satisfaction and Practice Sustainability Group is in the process of conducting a study focusing on how physicians spend administrative time in office-based practices, which will include a review of time spent on prior authorization requests. The study is proposed to take place in 2015, with results available in early 2016. Previous AMA advocacy efforts have also developed a prior authorization whitepaper and workflow model to reduce the burdens associated with prior authorization.

Given this ongoing advocacy and the similar concerns highlighted by these resolutions, your Reference Committee recommends that a substitute resolution be adopted in lieu of Resolutions 215, 219, 221, and 222. The substitute resolution reaffirms existing policy aimed at reducing precertification and utilization review efforts and would also include proactive recommendations to study and quantify the burden associated with these utilization review tools to further inform AMA advocacy. Your Reference Committee believes that the language of this substitute resolution captures the concerns expressed in the testimony and is sufficiently broad to maximize the flexibility of AMA advocacy efforts to minimize administrative burdens on physicians. Therefore, your Reference Committee recommends adoption of Substitute Resolution 215 in lieu of Resolutions 215, 219, 221, and 222.

H-320.950 Eliminating Precertification

Our AMA will: (1) advocate that all utilization review efforts focus on statistical outliers, rather than routine blanket review of whole populations of physicians or all instances of particular services; (2) advocate that managed care plans restrict their preauthorization requests to physicians whose claims have shown to be statistical outliers; and (3) encourage CMS to adopt regulations prohibiting Medicare secondary insurance carriers from utilizing independent precertification criteria. (Res. 705, A-99; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation I-10)

(12) **RESOLUTION 201 – SHORT-TERM URGENT REFILLS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 201 be referred.

HOD ACTION: Resolution 201 referred.

Resolution 201 asks that our American Medical Association develop a policy that short-term urgent refills should be allowed once a month for certain critical medications when authorization for refill is not readily available after hours, on weekends and on holidays, and that this recommendation be sent to the Food and Drug Administration and other vested parties, and ask that the same parties generate a list of critical medications qualifying for a short-term urgent refill (Directive to Take Action); and that our AMA generate model state legislation to allow short-term urgent refills for certain critical medications as often as once a month. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 201. Those in favor of the resolution discussed that delaying refills can negatively impact patient health. Those opposed to the resolution, however, noted concerns with the frequency that refills should be allowed and whether this resolution could create liability concerns for physicians and pharmacists. Others noted that pharmacists already have the authority in some instances to dispense limited quantities of critical medications while the refill request is being adjudicated. Your Reference Committee recognizes these questions and is also concerned that the "critical" variable included in this resolution will be a moving target and may complicate AMA advocacy. Your Reference Committee therefore believes that this resolution should be referred to address these complex issues in more detail.

(13) RESOLUTION 213 – CANNABIS – EXPANDED AMA ADVOCACY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 213 be referred.

RESOLVED, That our American Medical Association ~~immediately initiate an aggressive campaign to educate the media and legislators as to the scientifically established health effects of chronic cannabis use and the potential public health, social and economic consequences of expanded use as elucidated in CSAPH Reports 2-I-13 and 3-I-09 and as additional scientific evidence becomes available.~~ (Directive to Take Action); and be it further

RESOLVED, That our AMA urge legislatures to delay initiating full legalization of any cannabis product until further research ~~by the US Food and Drug Administration, the Drug Enforcement Administration, and others~~ is completed on the public health, medical, economic and social consequences of ~~chronic~~ use of cannabis and, instead, support the expansion of such research; (Directive to Take Action) and be it further

RESOLVED, That that our AMA also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a “public health”, as contrasted with a “criminal,” approach to cannabis. (Directive to Take Action)

RESOLVED, That our AMA should encourage model legislation that would require placing the following warning on all cannabis products not approved by the US Food and Drug Administration: “Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States.” (Directive to Take Action)

HOD ACTION: Resolution 213 adopted as amended.

Resolution 213 asks that our American Medical Association immediately initiate an aggressive campaign to educate the media and legislators as to the scientifically established health effects of chronic cannabis use and the potential public health, social and economic consequences of expanded use (Directive to Take Action); and that our AMA urge legislatures to delay initiating full legalization of any cannabis product until further research by the US Food and Drug Administration, the Drug Enforcement Administration, and others is completed on the public health, medical, economic and social consequences of chronic use of cannabis and, instead, support the expansion of such research; (Directive to Take Action) and that our AMA also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a “public health”, as contrasted with a “criminal,” approach to cannabis. (Directive to Take Action)

Your Reference Committee heard extensive testimony related to Resolution 213. Your Reference Committee agrees with testimony lauding the work of our AMA Council on Science and Public Health related to its seminal report adopted by our House of Delegates in November 2013. Your Reference Committee also acknowledges testimony related to the frustration that much of the media has greatly overstated the alleged medical efficacy and uses of cannabis and ignored the scientific evidence and the need for expanded research regarding the potential negative impact of chronic cannabis use. Those testifying in favor of the resolution argued that our AMA should educate both the media and legislators as to the dangers of chronic cannabis use and advocate against full cannabis legalization until there is more research. On the other hand, your Reference Committee also heard testimony that immediately launching an aggressive educational campaign, as called for in Resolve 1, would divert AMA resources from its top priorities. The issues surrounding cannabis are extremely complex. Before our AMA launches educational campaigns of any kind—be they to educate the media, legislators and/or the public—your Reference Committee

believes that Resolution 213 needs to be referred to study and understand the effects of chronic cannabis use. Referral will allow our Board of Trustees to ensure that our AMA's actions are not premature and are only taken after full consideration of available evidence. Therefore, your Reference Committee recommends that Resolution 213 be referred.

(14) RESOLUTION 214 – PAIN MEDICINE

RECOMMENDATION:

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

HOD ACTION: Resolution 214 referred.

Resolution 214 asks that our American Medical Association work to remove the pain survey questions from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and work to prevent the Centers for Medicare & Medicaid Services (CMS) from using pain scores as part of CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys (Directive to Take Action); and that our AMA request that CMS educate the public about the real risk of narcotic use and patient responsibility (Directive to Take Action); and that a patient and physician education program for non-narcotic pain control directed at the risk of addiction, diversion and abuse from prescription narcotics be promoted by our AMA (Directive to Take Action); and that our AMA advocate that commercial insurance and CMS payment for non-pharmaceutical treatments should be increased and also advocate for payment for team-based care of the pain patient (Directive to Take Action); and that our AMA should encourage CMS to work with the states to develop non-punitive drug monitoring programs for physicians and patients to help reduce the use of prescription pain drugs. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 214. Testimony differed on how to best balance legitimate medical access to pain medicine while protecting public safety. Testimony also highlighted the existing AMA multi-prong strategy that leverages engagement with a range of stakeholders among physicians, other prescribers, public health officials and other stakeholders to combat prescription drug abuse. For example, our AMA has engaged with a broad range of federal agencies, including the US Drug Enforcement Administration and a number of agencies within the US Department of Health and Human Services, including the Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services (CMS), and Substance Abuse and Mental Health Services Administration, along with collaboration with state-focused groups, such as the National Governors Association. In addition, our AMA has already engaged CMS to address the concerns raised regarding the HCAHPS pain survey. Other testimony described the range of existing AMA policies that already address all of the resolves contained in Resolution 214. Your Reference Committee also notes that our AMA has over the past several years actively worked to implement these policies as demonstrated with the AMA site: www.ama-assn.org/go/stopdrugabuse.

Importantly, your Reference Committee heard testimony that our AMA Council on Medical Service is currently developing a report on these and other issues related to prescription drug abuse. Your Reference Committee believes that referral of Resolution 214 will allow for the important issues raised in Resolution 214 to be taken into consideration and addressed in this pending report. Therefore, your Reference Committee recommends that Resolution 214 be referred.

(15) RESOLUTION 226 – EXTENSION OF DEADLINE TO FILE CLAIM FOR FICA TAX REFUND

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 226 be referred for decision.

HOD ACTION: Resolution 226 referred for decision.

Resolution 226 asks that our American Medical Association investigate the number of unclaimed FICA tax refunds by medical residents (Directive to Take Action); and that, if the number of unclaimed FICA tax refunds is significant, our AMA seek federal legislation to extend the deadline to apply for FICA tax refunds prior to 2005. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 226. Those who testified in support of adoption argued that medical residents have been denied tax refunds due to unclear deadlines and institutions that failed to submit necessary paperwork. Others stated trying to investigate refunds, especially tax returns that are over a decade old, will divert resources and attention away from key AMA priorities and may be exceedingly costly and difficult. Your Reference Committee recognizes that the issues raised by this resolution are complex but could be important to our members. In order to ensure that our AMA is best positioned on the issues raised in Resolution 226, your Reference Committee recommends that Resolution 226 be referred for decision.

(16) RESOLUTION 220 – PROTECTING PATIENTS’ ACCESS TO PRESCRIPTION DRUGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 220 not be adopted.

HOD ACTION: Resolution 220 not adopted.

Resolution 220 asks that our American Medical Association engage other stakeholders, which may include, but not be limited to, the US Food and Drug Administration, and Executive Branch, Congress, consumer and public advocacy organizations (e.g., AARP, Public Citizen, etc.) or other non-governmental organizations, and other appropriate stakeholders for the purpose of educating stakeholders and developing and implementing strategies to protect access for our patients to effective, safe, and affordable drugs in the face of the pharmaceutical industry’s current practices. These strategies may include, but not be limited to, federal policy change, public education, methods to bring the public’s and the AMA’s concerns to the pharmaceutical industry and other decision makers. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 220, insufficient to support adoption. Furthermore, your Reference Committee believes that the Resolve clause constitutes an unclear directive to our AMA. Your Reference Committee strongly believes that it is important to address policies that decrease access to clinically appropriate, affordable medication through a strategy of broad engagement with diverse stakeholders including the government and other impacted stakeholders, and recognizes testimony offered on other resolutions that highlighted multifaceted and ongoing AMA advocacy on these issues. Given limited testimony and existing AMA advocacy, your Reference Committee recommends that Resolution 220 not be adopted.

(17) RESOLUTION 227 – 2015 MEDICARE PHYSICIAN FEE SCHEDULE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 227 not be adopted.

HOD ACTION: Resolution 227 not adopted.

Resolution 227 asks that our AMA convene/host a series of discussions about the 2015 Medicare Physician Fee Schedule among all concerned specialty societies (Directive to Take Action); and that our AMA appeal to CMS to delay implementation of the 2015 Medicare Physician Fee Schedule Final Rule pending an in-depth study of the impact the rule will have on the Medicare/Medicaid population (Directive to Take Action); and that our AMA report back to the House of Delegates as soon as possible, preferably by A-15. (Directive to Take Action).

Your Reference Committee heard testimony against adoption of Resolution 227. Testimony highlighted that our AMA did convene and host a series of discussions on the 2015 Medicare Physician Fee Schedule Proposed Rule and specifically sought feedback from specialty societies on all aspects of the rule. In addition, those testifying noted that our AMA received additional specialty feedback through the RVS Update Committee (RUC), which provided detailed technical comments on many of the rule's provisions. This feedback was then incorporated into a comprehensive comment letter on the proposed rule, which provided 93 pages of recommendations and suggested changes. Additional testimony noted that suspending implementation of the final rule would also delay the positive aspects of the regulation that benefit physicians, such as payment for chronic care management codes and telehealth services as well as reduced penalties for the value-based payment modifier. Based on this testimony, your Reference Committee agrees that delay of the Physician Fee Schedule is unlikely and may have negative consequences for some physicians. Your Reference Committee, therefore, recommends that Resolution 227 not be adopted.

(18) RESOLUTION 206 – HELP CONTROL PHARMACEUTICAL COSTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-330.954 be reaffirmed in lieu of Resolution 206.

HOD ACTION: Resolution 206 adopted.

Resolution 206 asks that our American Medical Association work toward eliminating Medicare prohibition on drug price negotiation. (Directive to Take Action)

Your Reference Committee heard testimony in support of the underlying principles set forth in Resolution 206. Pharmaceutical costs have risen in a dramatic fashion in the last decade, and your Reference Committee agrees that these costs are putting tremendous pressure on our country's health care system. Your Reference Committee heard testimony on the effects that these rising costs are having on patients. Most notably your Reference Committee heard about patients that are postponing care, putting off purchasing needed medications, refills and/or skipping doses altogether. Your Reference Committee agrees that our patients need relief from these escalating costs. Your Reference Committee also heard testimony from our AMA Council on Legislation that AMA policy already exists that covers the goals of Resolution 206. Specifically, AMA Policy D-330.954 asks that our AMA support federal legislation that gives the Secretary of the US Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. Given that this existing AMA policy covers the intent of Resolution 206, your Reference Committee recommends reaffirmation of AMA Policy D-330.954 in lieu of the Resolution 206.

D-330.954 Prescription Drug Prices and Medicare

Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11)

(19) RESOLUTION 209 – EXPANSION OF SAFE DRUG DISPOSAL SITES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-95.945, H-135.936, and D-135.993 be reaffirmed in lieu of Resolution 209.

RESOLVED, That our American Medical Association work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. (Directive to Take Action)

RESOLVED, That our AMA work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.

HOD ACTION: Resolution 209 adopted as amended.

Resolution 209 asks that our American Medical Association work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. (Directive to Take Action)

Testimony on Resolution 209 was supportive. Your Reference Committee agrees that proper use, storage, and disposal of prescription medications are critical. Your Reference Committee recognizes the issues raised in testimony and at the same time is impressed with the amount of work our AMA is doing to advocate on issues related to prescription drug abuse and diversion – with safe medication storage and disposal being one of the many issues being addressed. Our AMA Council on Legislation testified about our AMA's on-going advocacy at both the federal and state levels and reminded our House of Delegates that we already have extensive existing policy to guide our work as it relates to safe drug disposal and other related issues. In particular, existing AMA policy provides that our AMA will promote medical school and postgraduate training that incorporates curriculum topics focusing on, among other things, safe medication storage and disposal practices. Our AMA also supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. Testimony also highlighted that our AMA has communicated to the Office of the National Drug Control Policy and the US Drug Enforcement Administration on several occasions as well as to Members of Congress, governors, state legislators and numerous national policy-making organizations related to efforts to streamline and facilitate easy access to disposal sites. Given this existing policy and advocacy, your Reference Committee recommends that AMA Policies H-95.945, H-135.936, and D-135.993 be reaffirmed in lieu of Resolution 209.

H-95.945 Prescription Drug Diversion, Misuse and Addiction

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths. (Res. 223, A-12)

H-135.936 Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs

Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. (Sub. Res. 515, A-10; Reaffirmation A-11)

D-135.993 Contamination of Drinking Water by Pharmaceuticals and Personal Care Products

Our AMA will: (1) request that the Environmental Protection Agency conduct studies to understand better the public health impact of discarded pharmaceuticals and personal care products on the nation's drinking water supplies; and (2) encourage the EPA and other federal agencies to engage relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for

physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems. (Res. 403, A-06)

(20) RESOLUTION 216 – SITE OF SERVICE PAYMENT DISCREPANCIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-400.957 and H-400.969 be reaffirmed in lieu of Resolution 216.

HOD ACTION: Policies H-400.957 and H-400.969 reaffirmed in lieu of Resolution 216.

Resolution 216 asks that our American Medical Association design and implement a legislative advocacy plan, with input of appropriate specialty societies, to reverse provisions in the Protecting Access to Medicare Act (PAMA) which allows CMS to establish physician practice expense payment based on comparisons across sites-of-service and authority to establish alternative approaches to establishing practice expense relative values. Specifically, but not all inclusively, targeting section 220: Ensuring accurate valuation of services under the physician fee schedule and any section that provides unlimited authority to the secretary. (Directive to Take Action)

Your Reference Committee heard testimony generally in support of Resolution 216. However, those testifying also noted that longstanding AMA policy and advocacy already call for practice expenses to reflect physicians' full, actual costs of providing a service in their office—or any site of service. Those testifying highlighted that recently, in 2013, at the urging of our AMA, specialties, and state medical societies, CMS withdrew its plan to cap Medicare payment for over 200 services in physician offices at the hospital outpatient or the ambulatory surgical center rate. Testimony noted that our AMA continues to actively fight the use of inappropriate comparisons for establishing physicians' practice expenses. Those testifying further cautioned that an ill-timed legislative effort could result in Congress adopting even worse provisions, and further complicating our efforts on this important issue. Consequently, your Reference Committee recommends reaffirmation of Policies H-400.957 and H-400.969 in lieu of Resolution 216.

H-400.957 Medicare Reimbursement of Office-Based Procedures

Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-04; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 3, A-14)

H-400.969 RVS Updating

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC). (BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13; Reaffirmed: Sub. Res. 104, A-14)

(21) RESOLUTION 218 – PARITY OF PAYMENT FOR ADMINISTRATION OF MEDICATIONS WITHIN THE SAME CATEGORY OF DRUG

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-390.921 be reaffirmed in lieu of Resolution 218.

HOD ACTION: Resolution 218 referred.

Resolution 218 asks that our American Medical Association use its influence and resources to secure Congressional outreach to the Centers for Medicare & Medicaid Services (CMS) with the objective that CMS issue guidance requiring parity of payment for administration of medications within the same category of drug. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 218. Testimony noted that this resolution raises questions about the clinical standards and levels of evidence employed by Medicare contractors when issuing local coverage determinations and that this is a complex issue. Other testimony highlighted that the goals of this resolution are generally covered by existing AMA policy on the uniformity of operations of Medicare Administrative Contractors that avoids the problems of congressional outreach, which may be difficult to secure. Your Reference Committee agrees that additional fact-finding and coordination is needed before pursuing a congressional strategy related to this issue. Therefore, your Reference Committee agrees with those testifying and supports reaffirmation of existing AMA Policy H-390.921 in lieu of Resolution 218.

H-390.921 Uniformity of Operations of Medicare Administrative Contractors

It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Medicare Administrative Contractors, and (2) to investigate and monitor the differing policies and procedures among the Medicare Administrative Contractors with respect to physician reimbursement. (Res. 154, A-90; Reaffirmed: Sunset Report, I-00; Modified: CMS Rep. 6, A-10)

(22) RESOLUTION 223 – PRESERVATION OF SMALL MEDICAL PRACTICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-405.988, H-478.991, and E-9.02 be reaffirmed in lieu of Resolution 223.

HOD ACTION: Policies D-405.988, H-478.991, and E-9.02 reaffirmed in lieu of Resolution 223.

Resolution 223 asks that our American Medical Association help ensure the continued viability of private practices by: (1) encouraging physicians to maintain their private practices; (2) seeking legislation to create waivers for private practices to continue to use non-electronic medical records with no financial penalty; and (3) seeking legislation to eliminate non-compete clauses for physicians who join hospital groups. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony with respect to Resolution 223. Testimony stated that private practices are facing numerous challenges, including regulatory burdens such as the Meaningful Use program. Testimony also noted that non-compete clauses can be a significant obstacle to physician movement in the marketplace. Other testimony highlighted that extensive AMA policy and advocacy already cover the goals of this resolution and pursuing a legislative bar could be exceedingly difficult given the current political environment. Your Reference Committee recognizes the significant burdens facing small medical practices and wishes to highlight the existing AMA advocacy and policy specifically targeted at the goals of this resolution to inform our AMA members and encourage use of available resources. In particular, our AMA has developed a comprehensive model contract to aid physicians as they contractually join a hospital and established an extensive educational practice platform known as STEPSforward™ (www.steps-forward.com) to assist physicians in solo and small group practices to improve

practice effectiveness and efficiency. The content of this new platform includes topics related to prescription management, patient visit preparations and documentation and will be expanded in the future. AMA policy also more broadly seeks to preserve private practices and repeal Meaningful Use penalties for all physicians, and our AMA has provided extensive comments to remove these regulatory burdens. Based on these existing AMA efforts, your Reference Committee recommends that Policies D-405.988, H-478.991, and E-9.02 be reaffirmed in lieu of Resolution 223.

D-405.988 The Preservation of the Private Practice of Medicine

Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice, with a progress report at the 2015 Annual Meeting; and (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option. (Res. 224, I-10; Appended: Res. 604, A-12; Reaffirmation I-13; Appended: Res. 735, A-14)

H-478.991 Federal EMR and Electronic Prescribing Incentive Program

Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13)

E-9.02 Restrictive Covenants and the Practice of Medicine

Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (VI, VII) Issued prior to April 1977; Updated June 1994 and June 1998.

(23) RESOLUTION 224 – TRANSPARENCY AND LABELING OF GENERIC MEDICATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-125.984 be reaffirmed in lieu of Resolution 224.

HOD ACTION: Policy H-125.984 reaffirmed in lieu of Resolution 224.

Resolution 224 asks that our American Medical Association pursue legislation that ensures the transparency of prescription generic drugs by ensuring that generic medications are adequately labeled according to US Food and Drug Administration (FDA) requirements, that FDA bioequivalence data is included in the package insert when the generic medication is delivered to the pharmacist, and that this bioequivalence data be made available to the patient or physician upon request. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony concerning Resolution 224. Our AMA Council on Legislation testified that existing AMA policy provides that our AMA will work with the US Food and Drug Administration and the US Pharmacopoeia to explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria to determine the bioequivalence of individual products. In light of the foregoing existing policy that covers the goals of Resolution 224, your Reference Committee urges reaffirmation of AMA Policy H-125.984 in lieu of Resolution 224.

H-125.984 Generic Drugs

Our AMA believes that:

- (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.
- (2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.
- (3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.
- (4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.
- (5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.
- (6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).
- (7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process. (CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 525, A-10)

(24) **RESOLUTION 229 – PREVENTING DRUG MANUFACTURERS FROM RESTRICTING THEIR DISTRIBUTION NETWORKS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-110.993, H-110.992, and H-110.998 be reaffirmed in lieu of Resolution 229.

HOD ACTION: Policies D-110.993, H-110.992, and H-110.998 reaffirmed in lieu of Resolution 229.

Resolution 229 asks that our American Medical Association establish as policy that we are opposed to attempts by drug manufacturers and distributors to increase profits by restricting the distribution of their medications (New HOD Policy); and that our AMA seek to partner with the American Hospital Association and other interested parties to oppose Genentech's plan to restrict the distribution of their products (Directive to Take Action); and that our AMA seek to convince the Federal Government that Genentech's plan to restrict the distribution of their drugs should be viewed and aggressively opposed as restraint of trade. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 229. This testimony noted that practices by pharmaceutical companies can drive up the cost of essential drugs and specifically highlighted concern with Genentech's distribution practices. Other testimony was supportive but noted that existing AMA policy already addresses the goals of this resolution, asking that our AMA monitor and discourage arrangements that could raise drug costs or impact availability of essential drugs. Those testifying also believed that the resolution was overly specific, focusing solely on one company's actions. Your Reference Committee agrees that existing policy covers the goals of Resolution 229 and more appropriately provides for broad directives rather than listing specific company practices. Given that this existing policy covers the intent of Resolution 229 in a more comprehensive manner, your Reference Committee recommends reaffirmation of Policies D-110.993, H-110.992, and H-110.998 in lieu of Resolution 229.

D-110.993 Reducing Prescription Drug Prices

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation. (CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14)

H-110.992 Study of Actions to Control Pharmaceutical Costs

Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Sub. Res. 114, A-01; Reaffirmed: Res. 533, A-03; Reaffirmed: CMS Rep. 4, A-13)

H-110.998 Cost of New Prescription Drugs

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

(25) **RESOLUTION 230 – AMA SUPPORT OF THE PREVENTIVE HEALTH SAVINGS ACT**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-155.994 be reaffirmed in lieu of Resolution 230.

HOD ACTION: Policy D-155.994 reaffirmed in lieu of Resolution 230.

Resolution 230 asks that our American Medical Association support the Preventive Health Savings Act (H.R. 2663/S. 1422) and send a letter to the Congressional Budget Office urging that it expand its scoring window to account for savings that may be generated by legislation that promotes disease prevention activities. (New HOD policy)

Testimony on Resolution 230 was limited. Those in support of the resolution stated that today's scoring by the Congressional Budget Office (CBO) fails to reflect savings beyond ten years and leaves an incomplete picture of the budget implications of proposed prevention policies. Other testimony highlighted that, while they agree with this concern, support of the Preventive Health Savings Act would not remedy this problem, but instead would merely direct the CBO to include a description and estimate of any reductions in budget outlays beyond the 10-year scoring window. Others noted that CBO is intended to be a non-partisan entity that does not make policy recommendations, limiting the ability for AMA to directly engage with it through lobbying efforts.

Your Reference Committee recognizes these concerns and agrees that the CBO's scoring mechanism often does not allow for long-term savings for improved health outcomes and can undermine the success of legislation. However, your Reference Committee notes that existing AMA policy more appropriately addresses the goals of Resolution

230 by asking that our AMA encourage efforts by CBO to more comprehensively measure long-term as well as short-term budget reductions and costs associated with legislation related to prevention of health conditions and effects. Because this policy more clearly addresses the intent of Resolution 230, your Reference Committee recommends reaffirmation of Policy D-155.994 in lieu of adoption.

D-155.994 Value-Based Decision-Making in the Health Care System

Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient. 2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress. (CMS Rep. 7, A-08)

REPORT OF REFERENCE COMMITTEE B

(1) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT
1 - SECTION ON MEDICAL SCHOOLS FIVE-YEAR REVIEW

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

**HOD ACTION: Council on Long Range Planning and Development Report 1
adopted and the remainder of the Report filed.**

In keeping with our AMA Bylaws, Council on Long Range Planning and Development Report 1 serves to summarize the Council's evaluation and make recommendations to the House of Delegates, through the Board of Trustees, regarding the ongoing delineated section status for the Section on Medical Schools. Through this report, the Council on Long Range Planning and Development recommends that our AMA renew delineated section status for the Section on Medical Schools through the 2019 Interim Meeting.

Your Reference Committee wishes to extend its appreciation to the Council on Long Range Planning and Development for a comprehensive review of the delineated section status of the Section on Medical Schools. In addition, your Reference Committee extends appreciation to the Section on Medical Schools for its cooperation in providing the Council with the necessary information. Having received no negative testimony, your Reference Committee favors the Council's recommendation.

(2) REPORT OF THE SPEAKERS - RULES FOR CAMPAIGN PARTIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in the Report of the Speakers – Rules for Campaign Parties be adopted and the remainder of the Report be filed.

**HOD ACTION: Report of the Speakers – Rules for Campaign Parties adopted
and the remainder of the Report filed.**

The Report of the Speakers recommends that Policy G-610.020, paragraph 6, be amended by addition to reinsert language limiting alcohol service at AMA election campaigns. The long-standing limitation appears to have been inadvertently rescinded with the adoption of an amendment by substitution to the policy at the 2014 Annual Meeting.

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 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; (Modify Current HOD Policy)

Your Reference Committee received testimony in support of the recommendation of the Speakers. Your Reference Committee wishes to extend its appreciation to our Speakers for addressing an oversight in the prior actions taken by our House of Delegates.

(3) RESOLUTION 601 - EMPLOYEE ASSOCIATIONS AND COLLECTIVE BARGAINING FOR PHYSICIANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 601 be adopted.

HOD ACTION: Resolution 601 adopted.

Resolution 601 calls upon our AMA to study and report back on physician unionization in the United States.

Your Reference Committee heard testimony indicating that physician unionization is a complex issue. While our AMA has policy addressing this topic, it has been a number of years since the medical practice environment has been studied, and the number of employed physicians in all practice settings has increased significantly. Your Reference Committee believes an updated study, as is called for by this resolution, would help our AMA House of Delegates to better understand the role of physician unions in an environment of increasing physician employment in diverse practice settings, both now and in the future.

(4) RESOLUTION 605 - HELPING TO BETTER INFORM LEGISLATORS ON MEDICAL MATTERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 605 be adopted.

HOD ACTION: Resolution 605 adopted.

Resolution 605 calls upon our AMA to inform members of Congress and their staff that *AMA Morning Rounds* is available without charge through our AMA website.

Your Reference Committee heard only supportive testimony for alerting members of the United States Congress that *AMA Morning Rounds* is available without charge via our AMA web site. Testimony also encouraged state medical societies to direct state political leaders to our AMA web site in order to access *AMA Morning Rounds*.

Your Reference Committee believes that anything our AMA can do to educate political leaders will serve to further aid our advocacy efforts on behalf of all physicians.

(5) RESOLUTION 607 - STUDY THE LONGER-TERM EFFECTS OF PHYSICIAN EMPLOYMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 607 be adopted.

HOD ACTION: Resolution 607 be adopted.

Resolution 607 calls upon our AMA to examine the potential long-term effects of trends in physician employment on patients and on the medical profession, and report back at the 2015 Interim Meeting. This examination should consider questions such as but not necessarily limited to:

- a) What factors have contributed most to increases in the proportion of physicians who are employed?

- b) How do employment and concomitant increases in rates of physician “turnover” affect continuity of care and patients’ perceptions that the physicians who treat them are dedicated to their long-term wellbeing?
- c) In what other ways might a physician’s employment status potentially affect the patient-physician relationship, and how might these effects, if problematic, be mitigated?
- d) How do increasing rates of employment affect the physician-hospital/health system relationship?
- e) How does employment affect physicians’ understanding of and will to engage in advocacy on issues that have historically been of significant importance to physicians, such as medical liability reform and physician reimbursement issues (e.g., SGR)? What effect will employment ultimately have on the collective voice of the medical profession?

Your Reference Committee received testimony highlighting that the number of employed physicians is increasing; however, the long term effects these models have on the patient-physician relationship and the profession overall are unknown. Testimony was heard urging that our AMA should study this issue and provide a comprehensive and balanced report at the 2015 Interim Meeting.

(6) **RESOLUTION 604 - AMA-PROVIDED INNOVATION GRANTS TO SUPPORT NEW PHYSICIAN MODELS TO IMPROVE QUALITY, EFFICIENCY AND REDUCE COST**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 604 be referred with report back at the 2015 Annual Meeting.

HOD ACTION: Referred with report back at the 2015 Annual Meeting.

Resolution 604 calls upon our AMA to develop innovation grants to explore new ways to improve quality and efficiency, and reduce cost in all medical practice settings, including independent private practice.

Your Reference Committee received testimony indicating our AMA is actively addressing the actions requested in this resolution through participation in the Centers for Medicare and Medicaid Services (CMS) Transforming Clinical Practice Initiative and through our AMA’s STEPS Forward™ (Solutions Toward Effective Practices), a comprehensive educational practice-based initiative currently in development.

Your Reference Committee supports referral of this resolution with a report back at the 2015 Annual Meeting, including more details about CMS’ Transforming Clinical Practice Initiative and the possibility of participating in a Support and Alignment Networks (SAN) award. Additionally, your Reference Committee heard testimony indicating a desire for more information about our AMA’s new STEPS Forward™ initiative.

(7) **RESOLUTION 606 - CREATION OF THE AMA SUPER PAC**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 606 be referred with report back at the 2015 Annual Meeting.

HOD ACTION: Referred with report back at the 2015 Annual Meeting.

Resolution 606 calls upon our AMA to create and fund an AMA Super PAC (Political Action Committee) to support or oppose candidates for Federal offices based on recommendations from state medical society PACs and supported by AMPAC (American Medical Association Political Action Committee). Additionally, the resolution charges an AMA Super PAC Board of Directors with the responsibility for determining the allocation of monies for

independent expenditures, active participation in all operational decisions regarding the independent expenditures, and development of a plan to encourage allowable contributions from other entities.

Resolution 606 further calls upon our AMA Board of Trustees to report back at the 2015 Annual Meeting with recommendations regarding the structure, organizing principles, name, membership, and terms of office of the organizing Board of Directors, as well as to present an annual budget for an AMA Super PAC.

Your Reference Committee received testimony indicating that the issue of creating an AMA Super PAC is complicated and warrants thorough analysis. Some key issues for consideration that were identified include: disclosure and reporting requirements, prudent use of our AMA reserves, potential impact on our AMA's tax status, risks to our AMA's reputation, potential to influence the outcome of key races, and impact on future AMPAC fundraising. Given the Federal elections that occurred earlier this week, there is ample time to analyze this matter before the next election cycle, and your Reference Committee believes that referral of Resolution 606 will allow for a balanced and comprehensive analysis.

REPORT OF REFERENCE COMMITTEE J

(1) BOARD OF TRUSTEES REPORT 1 - PAP TESTING GUIDELINES: HEDIS VERSUS USPSTF

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 1 adopted and the remainder of the report filed.

Board of Trustees Report 1 responds to referred Resolution 118-A-13, which asked our AMA to urge third party payers not to withhold payment to physicians for preventive health services that fall under accepted guidelines, even if they differ from the payer's own guidelines. The report recommends amending Policy H-450.947, Pay for Performance Principles and Guidelines, to specify that programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, and amending Policy H-410.953, Ethical Considerations in the Development of Medical Practice Guidelines, to specify that clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

There was limited testimony on Board of Trustees Report 1. Your Reference Committee appreciates the Board's thorough consideration regarding the specific issue of discrepancies between HEDIS and USPSTF guidelines related to pap testing, and the broader issue of payers declining payment for services that are consistent with current, accepted clinical guidelines if conflicting or alternate guidelines exist. Your Reference Committee believes that the policy amendments recommended in Board of Trustees Report 1 strengthen and clarify AMA policy related to physician payment for services that are consistent with clinical practice guidelines, and recommends that the recommendations in the report be adopted.

(2) COUNCIL ON MEDICAL SERVICE REPORT 6 - THE FUTURE OF EMPLOYER-SPONSORED INSURANCE

RECOMMENDATION:

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

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

Council on Medical Service Report 6 provides background on employer-sponsored insurance; outlines provisions in the Affordable Care Act (ACA) that impact employer-sponsored insurance; highlights the emergence of private health insurance exchanges; and presents policy recommendations to maximize employee choice of health plan and encourage the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage.

There was limited testimony on this report. A member of the Council on Medical Service noted that the intent of the report was to identify ways to maximize patient choice as the provisions of the ACA that impact employer-sponsored insurance are implemented. Your Reference Committee appreciates the Council's thorough overview of the potential implications of the ACA on employer-sponsored insurance and agrees that it is important to identify and encourage opportunities to expand coverage options for employees who have access to health insurance

coverage or subsidies through their employers. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted.

(3) RESOLUTION 810 - PATIENT EDUCATION REGARDING THE MEDICARE CHRONIC CARE MANAGEMENT FEE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 810 be adopted.

HOD ACTION: Resolution 810 adopted.

Resolution 810 asks that our AMA create a model letter that members may use to explain the Medicare chronic care management fee to their patients.

There was supportive testimony on this resolution. Your Reference Committee agrees that it would be very helpful to have a model letter developed by our AMA to help patients understand the value of chronic care management services and their responsibility with respect to acknowledging receipt of services and possible copay obligations.

(4) RESOLUTION 826 - NON-FORMULARY MEDICATIONS AND THE MEDICARE PART D COVERAGE GAP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 826 be adopted.

HOD ACTION: Resolution 826 adopted.

Resolution 826 asks that our AMA advocate for the inclusion of out of pocket, non-formulary, prescription medication expenses in calculating a patient's contributions toward the Medicare Part D coverage gap, and advocate for economic assistance, for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.

Your Reference Committee agrees with supportive testimony on Resolution 826 and recommends that it be adopted.

(5) RESOLUTION 824 - TETANUS VACCINE TO MEDICARE PATIENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 824 be adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 824 be changed to read as follows:

TETANUS AND TDAP VACCINE TO MEDICARE PATIENTS

HOD ACTION: Resolution 824 adopted as amended by addition of a second resolve with a title change.

That our AMA aggressively petition the Centers for Medicare and Medicaid Services to include coverage and payment for any vaccinations administered to

Medicare patients that are recommended by the Advisory Council on Immunization Practices (ACIP), the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines. (Directive to Take Action)

New Title: Vaccines to Medicare Patients

Resolution 824 asks that our AMA aggressively petition the Centers for Medicare and Medicaid Services to include tetanus and Tdap at both the “Welcome to Medicare” and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional “triggering event codes” that allow for coverage and payment of vaccines to Medicare recipients.

There was supportive testimony on this resolution. Although there was some concern about singling out the tetanus and Tdap vaccines, your Reference Committee notes that strong AMA policy exists that supports coverage for all recommended vaccines (e.g., H-440.875 and H-440.860). Your Reference Committee was persuaded by testimony indicating that the actions called for in Resolution 824 have the potential to create a new pathway to achieve the goal of expanding access to the tetanus and Tdap vaccines within the context of current Medicare rules. Accordingly, your Reference Committee recommends that Resolution 824 be adopted, and that the title be changed to include a reference to Tdap as well as tetanus, as both vaccines are important to the Medicare population.

(6) COUNCIL ON MEDICAL SERVICE REPORT 1 - HOSPITAL ADMISSIONS AND PATIENT MANAGEMENT CONTRACTORS

RECOMMENDATION A:

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

1. That our American Medical Association (AMA) continue to work with state medical associations to monitor utilization management policy to ensure that hospital admissions are reviewed by appropriately qualified physicians and promote related AMA model legislation. (Directive to Take Action)

RECOMMENDATION B:

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

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

Council on Medical Service Report 1 provides background on Medicare hospital admissions policy and utilization review of inpatient admissions. The report recommends that our AMA continue to work with state medical associations to monitor utilization management policy to ensure that hospital admissions are reviewed by appropriately qualified physicians. It also recommends reaffirmation of several policies that reinforce the concept that individuals employed by or under contract to provide patient status reviews are engaged in the practice of medicine and, as such, should maintain a license to practice medicine.

Testimony on Council on Medical Service Report 1 was very supportive. Several speakers expressed appreciation for the Council’s thorough discussion of Medicare hospital admissions policy and utilization review of inpatient admissions. Testimony also supported the report’s recommendation to continue working with states to ensure that the medical judgment of treating physicians is not overridden by personnel who are not qualified to do so. It was suggested that the AMA develop model legislation to address these issues. Model legislation has already been developed; therefore, your Reference Committee recommends the addition of language regarding promotion of this

model legislation. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted as amended.

(7) COUNCIL ON MEDICAL SERVICE REPORT 2 - PRIVACY ISSUES
REGARDING INSURANCE COMPANY EXPLANATION OF BENEFITS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Council on Medical Service Report 2 be amended by addition to read as follows:

2. That our AMA advocate that electronic medical record (EMR) vendors be required to create user-triggered mechanisms that alert health care professionals of confidential medical information that should be safeguarded. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 6 of Council on Medical Service Report 2 be amended by deletion to read as follows:

6. That our AMA advocate that health insurers be required to develop a method of listing health care services on Explanation of Benefits statements that would preserve confidentiality for all insured individuals, ~~such as using non-descriptive terminology for the services provided~~. (New HOD Policy)

RECOMMENDATION C:

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

HOD ACTION: Council on Medical Service Report 2 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 2 responds to referred Resolution 801-I-13, which asked our AMA to advocate for insurance company processes that would maintain privacy for adults and dependents who are insured through someone else. The report provides background on explanation of benefits (EOB) privacy issues for minors and adults, summarizes methods of establishing privacy for minors and adults, outlines health insurer privacy practices, and makes recommendations to help maintain confidentiality of sensitive information.

Testimony was generally supportive of Council on Medical Service Report 2. Several speakers thanked the Council for its respectful stance toward patients who are not policy holders, particularly young adults who can obtain coverage as dependents up to age 26 under provisions of the Affordable Care Act. Your Reference Committee agrees with testimony emphasizing the importance of privacy to patients seeking treatment for sensitive issues. Furthermore, your Reference Committee agrees that a perceived lack of confidentiality may in some instances deter minors and young adults from seeking medical care.

Your Reference Committee commends the Council for its balanced approach that considers the interests of both patients and policy holders. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended with clarifications to Recommendations 2 and 6 that are based on testimony.

(8) COUNCIL ON MEDICAL SERVICE REPORT 3 - REFERENCE PRICING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Recommendation in Council on Medical Service Report 3 be amended by addition on lines 38 – 40 to read as follows:

That our American Medical Association support the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles:

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Principle 2 of the Recommendation in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

2. Appropriate Reference pricing strategies may should be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Principle 3 of the Recommendation in Council on Medical Service Report 3 be amended by deletion to read as follows:

3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers ~~at or below the reference price~~. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Principle 4 of the recommendation in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

4. Hospitals or facilities Providers delivering services subject to reference pricing should avoid cost-shifting from one set of services to another. Providers should not knowingly reduce fees for those services and simultaneously increase fees for other services that are not subject to reference pricing coverage limits.

RECOMMENDATION E:

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

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

Council on Medical Service Report 3 responds to referred Resolution 808-I-13, which asked that the term “reference pricing” be substituted for the term “benefit payment schedule” in AMA policy, and that the AMA advocate for the option of “reference pricing” in a pluralistic approach to health system reform. The report explains the concept of reference pricing, describes examples of how this strategy may be used to influence health care costs in an insurance market, and makes recommendations to ensure that reference pricing strategies do not compromise the quality of patient care.

There was generally supportive testimony on Council on Medical Service Report 3. Several amendments were offered to clarify and strengthen the report recommendation and the principles that should govern reference pricing strategies. Your Reference Committee agreed with testimony that the language in the recommendation should be amended to clarify that reference pricing is one of many possible approaches to providing health insurance coverage. Recommendations A and B address this concern.

Some speakers raised concerns that Principle 3 of the recommendation implied that reference pricing would restrict patient access to providers whose charges exceeded the reference price. The intent of this Principle was to ensure that health plans set reference prices at an appropriate level that would allow patients access to a choice of providers. Recommendation C reflects testimony, supported by the Council on Medical Service, which removes language that appears to restrict patient choice to only low-cost providers.

Finally, there was concern that Principle 4 as written could be interpreted as restricting the ability to implement legitimate fee increases irrespective of reference pricing policies. Recommendation D reflects testimony that suggested amended language to focus on mitigating the risk of hospital and facility pricing strategies that would cost-shift among services.

Several speakers noted that issues related to transparency in health care costs and quality are closely related to reference pricing. The Chair of the Council on Medical Service acknowledged a request to include a discussion of reference pricing and benefit payment schedules in an upcoming report on price transparency, which will be presented to the House at the 2015 Annual Meeting.

Your Reference Committee is aware that the concept of reference pricing is receiving increased attention in public policy circles, and believes that the recommendations as amended in Council on Medical Services Report 3 will provide an important framework that our AMA can use to evaluate and help shape future developments related to the use of reference pricing systems.

(9) COUNCIL ON MEDICAL SERVICE REPORT 4 - NETWORK ADEQUACY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 of Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

5. That our AMA support requiring that provider terminations without cause changes to provider networks to be done established prior to the enrollment period, and thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product throughout the coverage year. Physicians may be added to the network at any time. (New HOD Policy)

HOD ACTION: Recommendation A adopted

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 6 of Council on Medical Service Report 4 be amended by addition on lines 45 – 50 to read as follows:

6. That our AMA support requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. (New HOD Policy)

HOD ACTION: Recommendation B adopted

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 8 of Council on Medical Service Report 4 be amended by addition and deletion on lines 7 – 11 to read as follows:

8. That our AMA advocate for regulation and legislation to require that provide that health insurers give reasonable credit for out-of- network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to based on network inadequacies, based on data from an independent medical charge database, toward a participant's annual deductibles and out-of-pocket maximums. (New HOD Policy)

HOD ACTION: Recommendation C adopted

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be amended by addition of a new Recommendation to read as follows:

That our AMA support fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. (New HOD Policy)

HOD ACTION: Recommendation D adopted

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be amended by addition of a new Recommendation to read as follows:

That our AMA support the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. (New HOD Policy)

HOD ACTION: Recommendation E adopted

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be amended by addition of a new Recommendation to read as follows:

That our AMA advocate for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited ~~deemed inadequate by the health plan or appropriate regulatory authorities~~. (Directive to Take Action)

HOD ACTION: Recommendation F adopted as amended

RECOMMENDATION G:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation 2 of Council on Medical Service 4 amended:

That our AMA reaffirm Policy H-285.991, which outlines requirements that must be met prior to initiation of actions leading to termination or non-renewal of a physician's participation contract for any reason, as well as requirements for an meaningful appeals process for physicians whose health insurance contract is terminated or not renewed. (Reaffirm HOD Policy)

HOD ACTION: Council on Medical Service Report 4 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 4 responds to three resolutions from the 2014 Annual Meeting that relate to network adequacy issues. The report provides an overview of the network adequacy of both exchange and Medicare Advantage plans, highlights emerging issues associated with out-of-network access to services, and presents recommendations to help ensure that networks provide meaningful access to all medically necessary and emergency care at the preferred, in-network benefit level on a timely and geographically accessible basis.

There was supportive testimony on Council on Medical Service Report 4, and your Reference Committee agrees that the recommendations in the report provide important safeguards to ensure that patients are not penalized for seeking care from out-of-network providers if their network provides inadequate coverage to meet the patient's medical needs. Several speakers offered amendments to strengthen and clarify the report recommendations, several of which your Reference Committee is recommending.

Your Reference Committee agrees with testimony suggesting amending Recommendation 5 to specify that terminations without cause from provider networks must occur prior to the start of the enrollment period, and clarify that new providers can be added to the network at any time.

Additional testimony suggested that it would be helpful to have additional data regarding the number of and type of providers who file in network and out-of-network claims with a health plan. Your Reference Committee agrees that this information would be useful, and recommends amending Recommendation 6 to include this suggestion. Proposed amendments to Recommendation 6 also reflect testimony calling for insurers to make data related to network adequacy publicly available. There was a suggestion that insurers be required to report data monthly rather than quarterly, but your Reference Committee believes that it is more realistic to specify quarterly reporting as the minimum interval for reporting requirements.

Your Reference Committee agrees with testimony expressing concern about the use of a third-party entity to determine the "reasonableness" of out-of-network medical charges that should be credited toward a patient's out-of-pocket limits. A member of the Council on Medical Service proposed amending Recommendation 8 regarding credit for out-of-network expenses by deleting the reference to using "an independent medical charge database" to

determine the credit amount. Your Reference Committee believes the amended language effectively addresses the concerns raised, and Recommendation C reflects this amendment.

Your Reference Committee also heard testimony suggesting that Recommendation 4 of the Council's report explicitly state our AMA's opposition to attempts to make a federal entity responsible for the primary enforcement of network adequacy. Although our AMA's preference is for state oversight of network adequacy, your Reference Committee notes that there may be instances where federal oversight of network adequacy is necessary, particularly in the case of federal programs (e.g., Medicare Advantage), or where state oversight is insufficient to preserve patient access. Accordingly, your Reference Committee recommends support for Recommendation 4 as written.

In response to testimony, your Reference Committee recommends the addition of three recommendations to the Council's report. One recommendation addresses concerns that out-of-network physicians may be forced to accept insurance payments that are significantly below acceptable rates. The Reference Committee's Recommendation D supports fair and equitable compensation for out-of-network providers when patients are required to go out of network.

Reference Committee Recommendations E and F reflect written testimony that was submitted to the Committee. Your Reference Committee agrees strongly that health insurance enrollees should have a mechanism to file formal complaints about network adequacy with appropriate regulatory authorities. Your Reference Committee also agrees that health insurers should be prohibited by law from falsely advertising the presence of physicians in a plan network.

Your Reference Committee commends the Council on Medical Service on a strong report that proposes a comprehensive approach to addressing network adequacy concerns, and recommends that the recommendations be adopted as amended.

(10) COUNCIL ON MEDICAL SERVICE REPORT 5 - MEDICAID EXPANSION OPTIONS AND ALTERNATIVES

RECOMMENDATION A:

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

2. That our AMA encourage states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low-income adult populations. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Council on Medical Service Report 5 be amended by addition and deletion to read as follows:

3. That our AMA encourage the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults residents. (New HOD Policy)

RECOMMENDATION C:

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

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

Council on Medical Service Report 5 provides an overview of the Medicaid expansion opportunity created by the Affordable Care Act (ACA), describes the role of waivers in the Medicaid expansion process, highlights alternative Medicaid expansion strategies that are being pursued by some states, and includes recommendations to encourage innovative approaches to expanding coverage options for adults who still lack access to affordable health insurance.

There was supportive testimony on this report. Your Reference Committee agrees with testimony suggesting that Recommendations 2 and 3 be amended to specify that Medicaid expansion alternatives should be pursued in order to expand coverage for low-income adults, which was the intent of the Medicaid expansion provision in the ACA. There was concern that the recommendations as written could have a negative impact on existing benefits provided to low-income children through the traditional Medicaid program. Your Reference Committee believes the amended language is consistent with the focus and intent of the Council's recommendations, and recommends adoption of the amended recommendations in Council on Medical Service Report 5.

(11) COUNCIL ON MEDICAL SERVICE REPORT 7 - MEDICAID PRIMARY CARE PAYMENT INCREASES
RESOLUTION 813 - MEDICAID ENHANCED RATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 7 be amended by addition to read as follows:

4. That our AMA advocate for the Affordable Care Act's Medicaid primary care payment increases to continue past 2014 in a manner that does not negatively impact physician payment for any other physicians. (Directive to Take Action)

HOD ACTION: Recommendation A adopted as amended**RECOMMENDATION B:**

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 7 be adopted as amended in lieu of Resolution 813 and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 7 adopted as amended and the remainder of the report filed.**HOD ACTION: Resolution 813 Not Adopted**

Council on Medical Service Report 7 responds to Resolutions 116-A-13 and 103-A-14, which relate to the eligibility of obstetricians and gynecologists for the Medicaid primary care payment increases and the extension of the temporary increase. The report recommends the inclusion of obstetricians/gynecologists as qualifying specialists for the primary care payment increases, and recommends extension of the increases beyond 2014.

Resolution 813 asks that our AMA work with other medical organizations to support the continuation of increased payments for primary care physicians who care for Medicaid patients so they receive payment at the federally-financed Medicare rate.

Testimony on Council on Medical Service Report 7 was largely supportive of the recommendations, although there was opposition among some speakers to the third and fourth recommendations. Your Reference Committee points out that support for this report in the online member forum, which was open for comments prior to the Interim Meeting, was unanimous and robust. Several speakers at the hearing commended the Council for its thoughtful and thorough examination of the issues and emphasized the importance of extending the Medicaid primary care payment increase which is due to expire at the end of the year. A representative of the Council on Medical Service reiterated that the recommendations in Council on Medical Service 7 are consistent with longstanding AMA policy (1) recognizing that obstetricians/gynecologists have the training and certification to practice as primary care physicians (Policy H-385.959); and (2) affirming that Medicaid payments to all physicians should be at minimum 100 percent of Medicare payment rates (Policy H-290.976).

It was suggested by some speakers that the third and fourth recommendations of the report be deleted and that, if the fourth recommendation is retained, that it be amended to clarify that any Medicaid primary care payment increases should not be offset by cuts to other physician payments. Your Reference Committee recommends amending Recommendation 4 to reflect this concern.

Your Reference Committee believes Recommendation 4 accomplishes the intent of Resolution 813, and therefore recommends that the recommendations in Council on Medical Service Report 7 be adopted in lieu of Resolution 813.

(12) COUNCIL ON MEDICAL SERVICE REPORT 8 - MODERNIZING TRICARE PAYMENT POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2a of Council on Medical Service Report 8 be amended by addition and deletion to read as follows:

2. That our AMA continue to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including:
 - a. establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered ~~by midlevel providers~~ while practicing as part of a physician-led health care team, consistent with state law, and
 - b. paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Council on Medical Service Report 8 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 8 addresses referred Resolution 108-A-14, which asked our AMA to advocate for changes in TRICARE payment policies to help strengthen patient access to care. The report recommends that our AMA encourage the Federation to respond to requests for information regarding potential TRICARE access issues

so that this information can be shared with TRICARE representatives; continue to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models; and continue to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services.

There was limited testimony on this report. Speakers raised concerns that Recommendation 2a as written could appear to be encouraging independent practice by midlevel providers. Your Reference Committee notes that our AMA has policy that defines and supports physician-led team based care (H-160.912), and policy that supports ensuring that payments for physician-led team-based care reflect the value provided by the team (Policy H-160.908). Encouraging TRICARE to pay 100 percent of TRICARE allowable costs for services rendered by midlevel providers while practicing as part of a physician-led health care team is consistent with these policies. Your Reference Committee believes that the amended language helps clarify that services rendered by midlevel providers should be eligible for 100 percent of the TRICARE allowable amount only if the providers are practicing as part of a physician-led health care team. Your Reference Committee supports the recommendations in Council on Medical Service Report 8, and recommends that they be adopted as amended.

(13) COUNCIL ON MEDICAL SERVICE REPORT 9 - REGULATION OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be amended by addition of a fourth Recommendation to read as follows:

4. That our AMA send a letter to the Centers for Medicare & Medicaid Services stating that the Clinical Laboratory Improvement Amendments (CLIA) requirements regarding provider-performed microscopy procedures and annual competency assessments are overly burdensome for physicians and their practices. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 9 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 9 addresses referred Resolution 715-A-14, which asked that our advocate for recognition of current certification systems and oppose overregulation of professional practitioners without clear demonstration of harm under current regulations and/or policies. The report recommends reaffirmation of policies that address CLIA regulations, Joint Commission standards and the burden of regulations on medical practice.

Testimony on this report was generally supportive. The onerous nature of some CLIA requirements related to microscopy was noted by several speakers. A letter to the Centers for Medicare & Medicaid Services regarding CLIA regulations governing provider-performed microscopy procedures and the annual competency assessments required for certification was suggested as a means for strengthening the report's recommendations. The Council on Medical Service indicated it was amenable to this suggestion, and your Reference Committee therefore recommends that Council on Medical Service Report 9 be adopted as amended with the addition of a fourth recommendation.

(14) RESOLUTION 801 - PATIENT ACCESS TO PENILE PROSTHESIS AS
LEGITIMATE TREATMENT FOR ERECTILE DYSFUNCTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 801 be
amended by deletion of the second Resolve to read as follows:

~~RESOLVED, That our AMA advocate that penile prosthesis not be excluded as part of the essential benefits package for health insurance plans sold through the state health insurance exchanges.~~ (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 801 be
adopted as amended.

HOD ACTION: Resolution 801 adopted as amended.

Resolution 801 asks that our AMA work with national specialty and state medical societies to advocate for patient access to the full continuum of care of evidence-based erectile dysfunction treatment modalities including oral pharmacotherapy, penile vasoactive injection therapy, vacuum erection device therapy and penile prosthetics, and advocate that penile prosthesis not be excluded as part of the essential benefits package for health insurance plans sold through the state health insurance exchanges.

Testimony on Resolution 801 was mixed. Some speakers emphasized the resolution's focus on patient access to a continuum of evidence-based treatments, including penile prosthesis surgery which is excluded from several states' exchange products. Other speakers, including a representative of the Council on Medical Service, testified that the AMA has policy that supports minimizing, not adding, benefit mandates to allow markets to determine benefit packages and permit a wide choice of coverage options. Your Reference Committee acknowledges the complicated nature of benefit mandates and recommends that Resolution 801 be adopted as amended by deletion of the second Resolve clause.

(15) RESOLUTION 803 - EMERGENCY DEPARTMENT INSURANCE
LINKING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 803 be
amended by addition to read as follows:

~~RESOLVED, That our American Medical Association support the establishment of insurance-linking programs in the emergency department in a manner that does not interfere with providing timely emergency medical services. (New HOD Policy)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 803 be
adopted as amended.

HOD ACTION: Resolution 803 adopted as amended.

Resolution 803 asks that our AMA support establishing insurance-linking programs in the emergency department in a manner that does not interfere with providing emergency medical services.

There was supportive testimony on this resolution. Your Reference Committee concurs with testimony that it is important to ensure that insurance-linking programs do not interfere with the timely provision of emergency medical services, and recommends that Resolution 803 be adopted as amended.

(16) RESOLUTION 809 - INSURANCE COVERAGE FOR FERTILITY
PRESERVATION IN PATIENT RECEIVING CYTOTOXIC OR
IMMUNOMODULATORY AGENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 809 be amended by addition and deletion to read as follows:

RESOLVED, That American Medical Association Policy H-185.990, Infertility and Fertility Preservation Insurance Coverage, be amended by insertion and deletion to read as follows:

1. The AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments oncologic treatments cytotoxic and/or immunomodulatory therapies as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments oncologic treatments cytotoxic and/or immunomodulatory therapies as determined by a licensed physician. (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 809 be adopted as amended.

HOD ACTION: Resolution 809 adopted as amended.

Resolution 809 asks that Policy H-185.990 be modified to replace the term “oncologic treatments” with the term “cytotoxic and/or immunomodulatory therapies.”

There was generally supportive testimony on this resolution. Your Reference Committee agrees with several speakers who noted that many necessary medical treatments may directly or indirectly affect fertility, and believes that the intent of Resolution 809 can be accomplished by expanding the language of Policy H-185.990 to support coverage for fertility preservation therapy services when fertility may be affected by any necessary medical treatment.

(17) RESOLUTION 811 - HEALTH PLAN COVERAGE FOR OUTPATIENT
OBESITY PRIMARY CARE VISITS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 811:

RESOLVED, that our AMA modify Policy D-440.954, Addressing Obesity, by addition to read as follows:

1. Our AMA will: (A) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (B) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (C) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). (BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14)

HOD ACTION: Substitute Resolution 811 adopted.

Resolution 811 asks that our AMA advocate and support state and federal efforts that would mandate universal health plan payment, including both private insurance and Medicaid, for pediatric primary care visits for childhood obesity/overweight.

Testimony on Resolution 811 was largely supportive. Consistent with AMA policy that supports minimizing health benefit mandates, there was a suggestion in testimony to change “mandate” to “support.” Speakers also generally favored broadening the scope of the resolution to be inclusive of all patients and not just pediatric overweight/obesity visits. Your Reference Committee points to Policy D-440.954 which, addresses patient access to the full continuum of obesity treatments, and recommends that this policy be modified to reflect a preponderance of the testimony.

(18) RESOLUTION 815 - BOARD RECERTIFICATION TO MAINTAIN HOSPITAL STAFF PRIVILEGES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~develop model changes to update model~~ hospital staff bylaws ~~to that will~~ address the problem of requiring board recertification to remain on staff (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that second Resolve of Resolution 815 be amended by deletion to read as follows:

~~RESOLVED, As our AMA develops model hospital staff bylaw changes with regards to board recertification, that several things be considered such as: 1) board certification may continue to be required for granting of initial hospital~~

~~staff privileges, and 2) subsequent board recertification may be just one of several options to retain staff privileges with other options or combination of being things such as participating in their specialty's maintenance of certification process, participating in their state's CME requirements, and serving on the medical staff in a continuous fashion with appropriate positive peer review and without any negative patient care issues (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 815 be amended by addition of a new Resolve to read as follows:

RESOLVED, That the AMA's representatives to The Joint Commission convey AMA Policies H-230.986 and H-230.997, which address board certification/recertification and hospital/health plan network privileges, to The Joint Commission.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 815 be adopted as amended.

HOD ACTION: Resolution 815 adopted as amended.

Resolution 815 asks that our AMA develop model hospital staff bylaws that address the problem of requiring board recertification to remain on staff, considering several things, such as: 1) board certification may continue to be required for granting of initial hospital staff privileges, and 2) subsequent board recertification may be just one of several options to retain staff privileges with other options or combination of being things such as participating in their specialty's maintenance of certification process, participating in their state's CME requirements, and serving on the medical staff in a continuous fashion with appropriate positive peer review and without any negative patient care issues.

Testimony was generally supportive of Resolution 815. The sponsor requested deletion of the second Resolve clause which your Reference Committee also recommends.

Your Reference Committee notes that Section 3.12 of the AMA Model Medical Staff Bylaws addresses certification and recertification and also understands that testimony supported taking another look at these bylaws. Your Reference Committee heard testimony advocating for direct AMA action to try and compel hospitals to comply with the AMA Model Medical Staff Bylaws and therefore recommends that Resolution 815 be adopted as amended with the addition of a new resolve.

(19) RESOLUTION 818 - ACCESS AND EQUITY IN TELEMEDICINE PAYMENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 818 be amended by addition and deletion to read as follows:

RESOLVED, The our American Medical Association establish as policy that there should be no geographic adjustment in payments for telemedicine, and lobby Congress to require advocate that the Centers for Medicare & Medicaid Services (CMS) to: 1) pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined "shortage" areas, if that area can show a shortage of

those physician specialists; and 2) ~~eliminate geographic adjustments for telemedicine payment to providers.~~ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 818 be adopted as amended.

HOD ACTION: Resolution 818 adopted as amended.

Resolution 818 asks that our AMA establish policy that there should be no geographic adjustment in payments for telemedicine, and lobby Congress to require the Centers for Medicare & Medicaid Services (CMS) to: 1) pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined “shortage” areas, if that area can show a shortage of those physician specialists; and 2) eliminate geographic adjustments for telemedicine payment to providers.

Testimony generally favored advocating that CMS pay for telemedicine services for patients who have difficulty accessing physician specialties that are in short supply in areas not federally designated as shortage areas but able to demonstrate a shortage of specialists nonetheless. Speakers rose in near unanimous opposition to eliminating the geographic adjustments to telemedicine payments, emphasizing that there are rationales for these geographic adjustments and that telemedicine services should be subject to the same Medicare payment processes as any other medical service. Your Reference Committee heard testimony that supported an amendment by the Pacific Rim delegation and recommends adoption of Resolution 818 as amended.

(20) **RESOLUTION 821 - REVIEW OF STRADDLE DRUG PRICING RULES FOR MEDICARE PART D PARTICIPANTS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 821 be adopted.

RESOLVED, That our AMA urge the Centers for Medicare and Medicaid Services (CMS) to examine how Medicare Part D plans are applying the straddle drug pricing rules and determine whether costs are being inappropriately shifted to beneficiaries whose drug spending totals span multiple coverage phases (Directive to Take Action); and be it further

RESOLVED, That our AMA prepare a report explaining the straddle drug pricing rules and their potential impact on patients, incorporating information that is available from CMS regarding implementation by Part D plans. (Directive to Take Action)

HOD ACTION: Substitute Resolution 821 adopted.

Resolution 821 asks that our AMA study the straddle drug pricing rules to ensure that costs are not being inappropriately shifted to Medicare beneficiaries during the gap phase, and report back the results of the study at the 2015 Annual Meeting, including an assessment of whether pharmacies are in compliance with the Affordable Care Act’s cost-sharing requirements during the gap phase.

There was mixed testimony on this resolution. Speakers indicated that the straddle drug pricing rules are complex and there is some evidence that some Part D plans are following billing practices that result in inappropriate increased cost-sharing by patients. Although a member of the Council on Medical Service testified that it might be appropriate for our AMA to ask the Centers for Medicare and Medicaid Services (CMS) to address this issue now, rather than waiting for the results of a study, the resolution sponsor and other speakers indicated the need for additional information to determine the scope of the problem and the specific issues that need to be addressed. Your

Reference Committee believes that CMS has a responsibility to investigate how straddle drug pricing rules are being implemented, and that they are in the best position to determine whether Part D plans are inappropriately shifting costs to patients. Your Reference Committee recommends substitute language that asks our AMA to raise this issue with CMS and ask them to gather information regarding the impact of the straddle drug pricing rules on patient cost sharing. The substitute language also requests that our AMA develop its own report about the straddle drug pricing rules, consistent with testimony calling for our AMA to educate physicians and patients about the complexity of the rules and their impact on patients.

(21) RESOLUTION 827 – CARE COORDINATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 827 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support, ~~in their patient centered medical homes~~, that they need to assure optimal outcomes (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 827 be adopted as amended.

HOD ACTION: Resolution 827 adopted as amended.

Resolution 827 asks that our AMA work with third-party payers to assure that payment of physicians/health care systems includes enough money to assure that patients and their families have access to care coordination support, and work with federal authorities to assure that funding is available to allow successful Center for Medicare and Medicaid Innovation (CMMI) grant-funded projects to provide information necessary to guide decisions that third-party payers make in their funding of care coordination services.

There was supportive testimony on this resolution. Your Reference Committee concurs with testimony that care coordination should be supported in all patient care contexts, and believes that deleting the specific reference to patient-centered medical homes strengthens the first resolve. Although concerns were raised that the second resolve is too prescriptive with respect to which programs CMMI should fund, your Reference Committee notes that advocating for continued funding of successful projects does not imply that CMMI should limit funding for new demonstration projects. Your Reference Committee believes that extending the funding of successful CMMI-funded projects will help maximize the benefits of the Innovation program by ensuring the these projects can continue to provide information and examples of best practices that emphasize care coordination activities and can inform payment models that support optimal care for patients. Accordingly, your Reference Committee recommends that Resolution 827 be adopted as amended.

(22) RESOLUTION 805 - INCORPORATING COMMUNITY HEALTH WORKERS INTO THE US HEALTH CARE SYSTEM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 805 be referred.

HOD ACTION: Resolution 805 referred.

Resolution 805 asks that our AMA encourage the incorporation of community health workers into the US health care system and support legislation that integrates community health workers into care delivery models especially in communities of economically disadvantaged, rural, and minority populations; and support appropriate stakeholder efforts to define the required level of training and scope of practice appropriate for community health workers.

There was mixed testimony on this resolution. Several speakers expressed concerns about potential scope of practice issues and encouraged referral in order to allow careful consideration of the appropriate role of community health workers. Your Reference Committee agrees that additional information is needed to determine how to best define the functions that should be performed by community health care workers and how they might be incorporated into physician-led health care teams. Accordingly, your Reference Committee recommends that Resolution 805 be referred.

(23) RESOLUTION 812 - HEALTH PLAN COVERAGE OF HEARING AID DEVICES
 RESOLUTION 817 - MEDICARE COVERAGE OF HEARING AIDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 812 and Resolution 817 be referred.

HOD ACTION: Resolution 812 and Resolution 817 referred.

Resolution 812 asks that our AMA support state advocacy efforts that would mandate universal health plan coverage of hearing aid devices to patients with hearing loss, regardless of age, to help them realize the potential benefits from appropriate amplification that is properly fit, adjusted and used as part of a comprehensive intervention plan. Coverage should also recognize the need for replacement of hearing aids due to maturation, change in hearing ability, and normal wear and tear.

Resolution 817 asks that our AMA support Medicare coverage of hearing aid devices, including external and implantable hearing aid devices.

Testimony on Resolutions 812 and 817 was mixed. Speakers testified passionately about patients who could benefit from hearing aids but do not have access to these devices due to the expense of hearing aids. Other speakers testified that these resolutions would lead to costly unfunded mandates. Your Reference Committee appreciates the complexity surrounding hearing aid coverage issues for people of all ages and therefore recommends referral for additional study.

(24) RESOLUTION 819 - PRICE TRANSPARENCY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 819 be referred.

HOD ACTION: Resolution 819 referred.

Resolution 819 asks that our AMA : 1) develop an educational program by early 2015 for physicians that would make healthcare price and reimbursement site differences clear; and 2) work with the Center for Healthcare Transparency (CHT), the Health Care Cost Institute (HCCI), and the Centers for Medicare & Medicaid Services (CMS) to make their websites easier to access and use, and make their data for hospital and physician prices and payments more accurate and useful for physicians, purchasers, and patients.

Testimony was generally supportive of the intent of Resolution 819. Several speakers noted that the issue of pay variations across sites of service has been addressed in two recent reports from the Council on Medical Service as well as a policy summary available on the Council's web page. It was also noted that data transparency will be the

topic of a Board of Trustees report that will be available at the 2015 Annual Meeting. A representative of the Council on Medical Service added that the topic of price transparency is currently under study by that Council with a report anticipated at the 2015 Annual Meeting.

It was further noted in testimony that the educational program requested by Resolution 819 would be onerous and perhaps unnecessary given the recent reports and those in the pipeline. Your Reference Committee agrees and recommends that Resolution 819 be referred.

(25) RESOLUTION 825 - PRINCIPLES FOR HOSPITAL SPONSORED ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 825 be referred.

HOD ACTION: Resolution 825 referred.

Resolution 825 asks that our AMA continue to urge Congress and the Centers for Medicare and Medicaid Services to mandate that all electronic health record (EHR) systems be interoperable, and to require hospitals to adhere to the following principles when a hospital or other sponsoring entity provides a subsidized EHR platform to a physician or medical group: 1. System must be interoperable; 2. physicians or medical groups entering into a subsidized EHR agreement with a hospital must maintain ownership and control of its patient data; 3. hospitals are prohibited from requiring physicians or medical groups to surrender their rights to own, control and access their patient data; 4. Hospital sharing of aggregated data may only occur with the written approval of the physician or medical group and may be fully revoked at the termination of the EHR agreement; 5. In the event a subsidized EHR agreement between a physician/medical group and a hospital is withdrawn or terminated, the hospital shall protect the physician/medical group's clinical data and promptly transfer the data to the contracted physician or medical group if such data was recorded in the treatment of the physician's/medical groups' patient; hospitals or other entities providing sponsored EHR must participate in regional health information exchanges when they become available to achieve meaningful use.

Resolution 825 raises important issues with respect to the ownership, access to and use of data when physicians use hospital sponsored electronic health records. A member of the Council on Legislation testified that the AMA has strong policy supporting the physician ownership of all data in electronic health records, and interoperability among EHR systems. Several speakers noted that issues associated with hospital-sponsored electronic medical records are complex and evolving and suggested that Resolution 825 be referred so that current regulations, practices and legal implications could be reviewed. Your Reference Committee agrees that this is an important and complicated topic that merits additional consideration, and accordingly recommends that Resolution 825 be referred.

(26) RESOLUTION 820 - ANTITRUST ACTIVITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 820 be referred for decision.

HOD ACTION: Resolution 820 referred for decision.

Resolution 820 asks that our AMA study the effects of monopolistic activity by healthcare entities that may have a majority of market share in a region on the patient-doctor relationship, and develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physicians and physician practices who are confronted with monopolistic activity by healthcare entities.

Testimony on Resolution 820 was largely supportive but also urged our AMA to proceed with caution. Speakers testified that the health care landscape is evolving and that consolidation of health care entities may be concerning in

some areas. A representative of the Council on Medical Service pointed to our AMA's annual environmental scan on Competition in Health Insurance: A Comprehensive Study of US Markets, and also a case study by AMA economists on the price effects of a large merger of health insurers in Nevada that suggested that premiums increased post merger. A representative of the Council on Legislation added that existing policies establish that antitrust relief will remain a top priority of the Association.

Your Reference Committee recognizes that our AMA is working on antitrust issues and also shares the angst of the sponsors of Resolution 820. Your Reference Committee agrees with multiple speakers who recommended that this item be referred.

(27) RESOLUTION 807 - MEDICAL EMERGENCY ALGORITHMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 807 not be adopted.

HOD ACTION: Resolution 807 not adopted.

Resolution 807 asks that our AMA support the following recommendations: 1. When providing advanced cardiac life support, advanced trauma life support, advanced pediatric life-support and other similar emergencies, health care facilities should maintain up-to-date suggested algorithms electronically or on paper and ensure that this information is readily accessible during the medical emergency, and 2. That health care facilities have a policy of providing a qualified person that the physician can designate to present the suggested algorithm during the active treatment.

There was mixed testimony on this resolution. The sponsor of the resolution indicated that the intent of the resolution was to ensure that guidance was available for medical personnel who are required to respond to medical emergencies that they may not frequently encounter in their regular practice. However, many speakers noted that physicians and medical facilities should be responsible for ensuring their preparedness for handling individual medical emergencies, and cautioned against reliance on algorithms as a substitute for physician judgment.

Additional testimony noted multiple other concerns about the proposed requirements that could expose physicians and hospitals to additional costs and liability issues. AMA policy is generally cautious with respect to clinical algorithms for these reasons. In particular, Policies H-410.971 and H-450.935 specify that algorithms and practice guidelines can aid physicians in the diagnosis and treatment of patients, but physicians should use their best judgment in treating their patients. Policy H-435.947 states that clinical practice guidelines should not supplant clinical judgment and failure to follow guidelines should not be used to create a presumption of negligence. Therefore, your Reference Committee recommends that Resolution 807 not be adopted.

(28) RESOLUTION 808 - ACCESS TO PSYCHIATRIC SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-345.981, H-345.978, H-385.921 and D-345.997 be reaffirmed in lieu of Resolution 808.

HOD ACTION: Policies H-345.981, H-345.978, H-385.921 and D-345.997 reaffirmed in lieu of Resolution 808.

Resolution 808 asks that our AMA advocate for improving access to psychiatric services by improving reimbursement; develop a policy that the reimbursement for psychiatric services for Medicaid patients be increased to Medicare levels; advocate for the addition of psychiatry to family practice, internal medicine, pediatrics and obstetrics and gynecology as those specialties require additional reimbursement for Medicaid patients to Medicare levels; and develop a policy that this increased reimbursement for Medicaid patients to Medicare levels be continued beyond the two years as stipulated in the Affordable Care Act.

Testimony on Resolution 808 was mixed. Several speakers described the shortage of psychiatrists in some areas and the difficulties patients have accessing psychiatric care. There was some opposition to the third and fourth Resolve clauses which would add psychiatry to the list of primary care specialties eligible for increased Medicaid payments addressed in Council on Medical Service Report 7-I-14. A Council on Medical Service representative reiterated that existing AMA policy supports access to mental health services as well as physician payments for all specialties at at least Medicare levels. Your Reference Committee agrees and recommends reaffirmation of Policies H-345.981, H-345.978, H-385.921 and D-345.978 in lieu of Resolution 808.

H-345.981 Access to Mental Health Services

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment. (CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13)

H-345.978 Access to Psychiatric Beds and Impact on Emergency Medicine

Our AMA supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness. (CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11)

H-385.921 Health Care Access for Medicaid Patients

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (Res. 103, A-07; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12; Reaffirmed: Res 132, A-14)

D-345.997 Access to Mental Health Services

Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process. (CMS Rep. 9, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 804, I-13)

(29) RESOLUTION 814 - SCIP AND HCAHPS MEASURES USED BY CMS IN HOSPITAL REIMBURSEMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-450.946, H-450.966, and D-385.958 be reaffirmed in lieu of Resolution 814.

HOD ACTION: Policies H-450.946, H-450.966, and D-385.958 reaffirmed in lieu of Resolution 814.

Resolution 814 asks that our AMA urge CMS, in conjunction with The Joint Commission, to: 1) review Surgical Care Improvement Project (SCIP) measures and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores used by CMS in hospital reimbursement, and 2) establish re-worked or alternate

criteria that are less punitive, less arbitrary and less burdensome on clinicians and hospitals and align better with established data for positive patient outcomes.

There was generally supportive testimony on the intent of this resolution and the need to streamline quality reporting programs and ensure that the measures used are evidence-based, valid, reliable, and linked to better patient health outcomes. A member of the Council on Legislation testified that our AMA's advocacy with the Centers for Medicare and Medicaid Services and other entities emphasizes the importance of identifying evidence-based quality measures that are relevant to physicians and patient care, and reflect input by practicing physicians. Your Reference Committee is aware that the SCIP and HCAHPS measures referenced in the resolution have recently undergone measure maintenance and updates are pending. While these updates may address the specific concerns identified in Resolution 814, your Reference Committee believes ongoing, broad-based advocacy will be necessary. Our AMA is actively engaged in activities to reduce the burdens associated with quality reporting programs, and existing AMA policy provides a strong foundation for continued AMA advocacy in this area. Accordingly, your Reference Committee recommends that the following policies be reaffirmed in lieu of Resolution 814:

H-450.946 Ensuring Quality in Health System Reform

Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles. (Sub. Res. 703, I-93; Reaffirmation A-01; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 704, A-12)

H-450.966 Quality Management

The AMA: (1) continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. (BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed in lieu of Res. 714, A-14)

D-385.958 Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment
Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Res. 102, A-13; Reaffirmed: Res. 806, I-13)

REPORT OF REFERENCE COMMITTEE K

(1) BOARD OF TRUSTEES REPORT 3 - FACILITATING STATE LICENSURE FOR TELEMEDICINE SERVICES

RECOMMENDATION:

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

HOD ACTION: Board of Trustees Report 3 adopted and the remainder of the report filed.

AMA Board of Trustees Report 3 reviews the Federation of State Medical Board's Interstate Compact for Medical Licensure and its application to facilitating state licensure for telemedicine services. The report recommends that our American Medical Association (1) support the Federation of State Medical Board's Interstate Compact for Medical Licensure; (2) work with interested medical associations, the Federation of State Medical Boards 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; (3) reaffirm Policies H-255.982, H-275.955, H-275.962, H-275.973, H-275.977, H-275.978, H-480.946, H-480.969, D-275.994, D-275.995 and D 480.999; and (4) rescind Policy D-480.971, which requested this report.

Your Reference Committee heard strong support for adoption of BOT Report 3. At the same time, there was concern expressed (and alternative language proffered) about the potential authority of the interstate commission that would be necessary to administer the Compact and whether that body might supersede and undermine the states' authority for physician licensing and discipline. Your Reference Committee understands, however, that the draft compact legislation being considered by individual state licensing boards, as stated in BOT Report 3, clearly stipulates that the interstate commission is not empowered to issue licenses, discipline physicians, or otherwise regulate changes to states' existing medical practice acts. That authority remains with the participating state licensing boards. Any rules developed by the commission will address operational and administrative functions only and will be developed solely by representatives from those states' medical boards that are participating in the compact. In addition, current AMA policy in opposition to national licensure obviates the need for this amended language. Your Reference Committee therefore recommends adoption of BOT Report 3.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - TORNADO SAFETY AND MANUFACTURED HOMES

RECOMMENDATION:

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

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

Council on Science and Public Health Report 3 reviews available standards and guidelines for the construction and installation of manufactured homes and assesses the vulnerability of these homes in tornadoes and other severe wind storms. The report recommends that (1) Owners of manufactured home parks should provide a plan, developed with and approved by local authorities, for the evacuation and sheltering of residents of the park in severe weather events such as tornadoes, high winds, or floods. The plan should advise residents of the vulnerability of manufactured homes in tornadoes and other extreme wind events and that evacuation to a safer location is necessary. The shelter or evacuation plan should be posted conspicuously in the park and the park owner should provide each resident with a copy of the approved shelter or evacuation plan; (2) State and local government authorities in regions at increased

risk for tornadoes and other extreme wind events should enact measures to either provide, or require owners of manufactured home parks in their jurisdiction to provide, as appropriate, an approved common storm shelter or safe room for all residents of manufactured homes in the park as protection against tornadoes and other extreme wind events; (3) Research is needed to enhance the design and construction of manufactured homes and manufactured home tie down/anchoring systems to withstand extreme wind forces and wind-blown debris; (4) Federal, state, regional, and local authorities should coordinate policies, processes, and procedures to ensure that manufactured homes are installed and inspected in accordance with established guidelines and standards, including requirements for the installation and inspection of tie down/anchoring systems; (5) Incentives should be developed for all homeowners (including those who live in manufactured homes), businesses, and local governments in regions at increased risk for tornadoes and other extreme wind events for the installation of home or community safe rooms and storm shelters, in accordance with federal and professional guidelines and standards; (6) All citizens should consider purchasing a NOAA Weather Radio All Hazards public alert radio for use in disasters and other emergency situations. Citizens also should develop a plan for where they will go and what they will do when a severe weather alert is issued.

The Council was thanked for its report, with limited but unanimous support for its recommendations. Testimony from those located in areas afflicted by tornadoes noted the devastation and subsequent health burdens that can arise from tornadoes, and how AMA policy will bring much-needed attention to measures intended to mitigate damage from disasters. Your Reference Committee agrees with the support of the report and recommends adoption of its recommendations.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 -ROLE OF PHARMACISTS IN IMPROVING IMMUNIZATION RATES

RECOMMENDATION:

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

HOD ACTION: Council on Science and Public Health Report 4 adopted and the remainder of the report filed.

Council on Science and Public Health Report 4 addresses the role of pharmacists in increasing immunization rates, summarizes state-level efforts authorizing pharmacists to administer vaccines, and promotes current guidelines and recommendations that apply to all vaccine providers. The report recommends that (1) Physicians and medical professional organizations should support state and federal efforts to engage pharmacists in vaccinating target populations that have difficulty accessing immunizations in a medical home. Before administration of a vaccine, pharmacists should assess the immunization status of the patient, which includes checking an immunization registry when one exists. Pharmacists should ensure that a record of vaccine administration is transmitted to the patient's primary care physician and documented in the immunization registry, and that written or electronic documentation is provided to the patient; (2) Vaccination programs in pharmacies should promote the importance of having a medical home to ensure appropriate and comprehensive preventive care, early diagnosis, and optimal therapy. Physicians and pharmacists should work together in the community to: (a) establish referral systems to facilitate appropriate medical care if the patient's conditions or symptoms are beyond the scope of services provided by the pharmacies; and (b) encourage patients to contact a primary care physician to ensure continuity of care; (3) State educational requirements for pharmacists who administer vaccines should be based on ACIP recommendations and recognized standards and guidelines derived with input from physicians and pharmacists with demonstrated expertise in immunization practices; (4) Policy H-440.877, "Distribution and Administration of Vaccines," should be amended by addition and deletion to read as follows:

AMA policy is that:

it is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record. (24) all physicians and other qualified health care

providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to the ACIP recommendations of the ACIP must be ensured timely access to adequate vaccine supply.(3) physicians and other qualified health care providers should: (a) incorporate immunization needs into clinical encounters, as appropriate; (b) strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines; (c) either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws; (d) ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists; and (e) maintain professional competencies in immunization practices, as appropriate.(2)(4) all vaccines should be administered by a licensed physician, or by a qualified health care provider under the supervision of a physician pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.(3) patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination was provided by someone other than the patient's primary care physician provider.(6) physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.(4)(7) ~~our AMA will work with~~ vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should to apply uniform bar-coding on vaccines based on standards promulgated by the medical community;

(5) That Policy H-440.899, "Immunization Registries," should be amended by addition to read as follows:

Our AMA encourages:

(1) physicians to participate in the development of immunization registries in their communities and use them in their practices for patients of all ages; (2) electronic health record (EHR) vendors to add features to automate the exchange of vaccination information in the patient EHR to state immunization registries to improve and help ensure completeness and accuracy of vaccination records. EHR vendors and registry administrators need to work with physicians and other health professionals to facilitate the exchange of needed vaccination information by establishing seamless, bidirectional communication capabilities for physicians, other vaccine providers, and immunization registries; and (3) all states to move rapidly to provide comprehensive lifespan immunization registries that are interfaced with other state registries; and

(6) That Policy H-160.921, "Store-Based Health Clinics," should be reaffirmed.

Council on Science and Public Health Report 4 addresses the contemporary role of pharmacists in increasing immunization rates, summarizes state-level efforts authorizing pharmacists to administer vaccines, and promotes current guidelines and recommendations that should apply to all vaccine providers. Health care settings beyond the traditional medical home currently play a role in the provision of vaccines, especially for adolescents and adults who do not receive primary care medical services through conventional venues. Improving immunization rates and reducing vaccine preventable illness across the lifespan is a critical public health priority. In accordance with AMA policy, the primary mode of vaccine delivery for pediatric patients, and for adult patients with chronic disease and co-morbidities, should be the primary care medical home to ensure coordination of care. However, when vaccines are administered in other settings, including pharmacies, the healthcare professional administering the vaccine has the responsibility: (1) to ensure that the patient is a candidate to receive the vaccine, and in a safe manner; (2) to transmit information on the vaccine administration to the individual's medical home so that it can be documented; and (3) supply that information to the immunization registry (when one exists) so that a complete vaccination record is maintained. Mechanisms should be developed and implemented to ensure that communication and record sharing are optimized between pharmacists and primary care physicians. This report views vaccine administration through a public health lens in a patient centered manner.

Substantial support was offered for the recommendations in this report including the Council on Medical Service, the Council on Legislation, and the Council on Long Range Planning and Development, as well as the original author of the resolution (Louisiana) that prompted the report. The importance of receiving vaccines in non-physician settings was deemed especially important for increasing access for minority populations. Some sentiment was expressed for referring the report back based on scope of practice issues. Additionally, skepticism about the

capability of existing EHR systems to facilitate communication was noted. Ultimately, the public health imperative of addressing vaccine-preventable disease is the overriding issue for this topic, so your Reference Committee recommends adoption.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - GENOMICS IN HYPERTENSION: RISK PREDICTION AND TREATMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Science and Public Health Report 1 be amended by addition on line 7 to read as follows:

1. Our American Medical Association encourages continued research on the genetic control of blood pressure, including in pediatric populations, and the development of genomic-based tools that may assist health professionals in better predicting risk and targeting therapy for hypertension. (New HOD Policy)

RECOMMENDATION B:

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

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

Council on Science and Public Health Report 1 reviews the genomic basis of hypertension and genomics-based tools used in hypertension risk assessment and treatment. The report recommends that our American Medical Association (1) encourage continued research on the genetic control of blood pressure and the development of genomic-based tools that may assist health professionals in better predicting risk and targeting therapy for hypertension; and (2) support the view that hypertension clinical trial designs should attempt to reduce phenotypic heterogeneity in order to improve the quality and interpretation of results.

Supportive testimony was offered on the Council's report. Hypertension remains a serious but preventable health problem in this country, and testimony noted the importance of developing additional tools to predict those who will be at risk, treat those with the condition, and ultimately prevent its onset. Genomic tools offer promise, and further research is warranted to explore their potential. The American Academy of Pediatrics requested that continued research include pediatric populations, and your Reference Committee agrees this is important since hypertension in the young is prevalent. Your Reference Committee notes that the second recommendation is about studies being designed to reduce genetic heterogeneity, and that it would not be appropriate to call out any specific population group for that concept. Therefore, your Reference Committee recommends adoption of an amended first recommendation and the original second recommendation.

(5) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 -
 ELECTRONIC CIGARETTES, VAPING AND HEALTH: 2014 UPDATE
 RESOLUTION 919 – PROHIBIT E-CIGARETTES IN HOSPITALS OR
 OTHER HEALTH CARE INSTITUTIONS
 RESOLUTION 927 – E-CIGARETTES AND PAID PRODUCT PLACEMENT
 RESOLUTION 930 – REGULATION OF ELECTRONIC NICOTINE
 DELIVERY DEVICES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Science and Public Health Report 2 be amended by addition on page 14, lines 14-21 to read as follows:

1. That Policy H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products be amended by addition and deletion to read as follows:

Our AMA supports:

(1) supports the US Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act ~~tobacco law~~, as amended by the Family Smoking Prevention and Tobacco Control Act. (2) supports legislation and/or regulation addressing the of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchaseing age of 18; locations of permissible use; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes, advertising and promotion activities, and sponsorship of e-cigarettes and all other non pharmaceutical tobacco/nicotine products; (3) (f) establishes manufacturing and product (including e-liquids) standards for product identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning the product design, contents of, and emissions; and from e-cigarettes and all other non pharmaceutical tobacco/nicotine products; (4) (h) restrictions prohibits on the use of characterizing flavors that may enhance the appeal of such products to youth minors, and the development of strategies to prevent marketing to, and use of, e-cigarettes and all other non pharmaceutical tobacco/nicotine products by minors; and (5) the prohibition of claims of reduced risk and/or the marketing of e-cigarettes as tobacco cessation tools until such time that credible evidence is developed that supports such claims.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Science and Public Health Report 2 be amended by the addition of a third recommendation to read as follows:

(3) That our AMA encourage further clinical and epidemiological research on e-cigarettes. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 2 be adopted as amended in lieu of Resolutions 919, 927 and 930, and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted as amended in lieu of Resolutions 919, 927 and 930, and the remainder of the report filed.

Council on Science and Public Health Report 2 review the use, regulation, and health information related to e-cigarettes. The report recommends (1) That Policy H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products be amended by addition and deletion to read as follows:

Our AMA supports:

(1) supports the US Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act ~~to tobacco law, as amended by the Family Smoking Prevention and Tobacco Control Act~~. (2) supports legislation and/or regulation addressing the of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; locations of permissible use, (b) prohibits use in all places that tobacco cigarette use is prohibited; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, advertising and promotion activities, and sponsorship of e-cigarettes and all other non-pharmaceutical tobacco/nicotine products; (f) establishes standards for product identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning the product design, contents of, and emissions; and from e-cigarettes and all other non pharmaceutical tobacco/nicotine products; (h) restrictions prohibits on the use of characterizing flavors that may enhance the appeal of such products to youth minors, and the development of strategies to prevent marketing to, and use of, e-cigarettes and all other non pharmaceutical tobacco/nicotine products by minors; and (5) the prohibition of claims of reduced risk and/or the marketing of e-cigarettes as tobacco cessation tools until such time that credible evidence is developed that supports such claims;

(2) That our AMA urge physicians to: (a) educate themselves about e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use 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; and (3) That Policy H-490.909 Use of Electronic Cigarettes (e-cigarettes) in Smoking Cessation Programs be rescinded.

Resolution 919 asks that our American Medical Association advocate for prohibition of the use of e-cigarettes by patients, visitors and health care personnel in hospitals and other health care institutions.

Resolution 927 asks that our American Medical Association (1) work through an appropriate federal process to prohibit e-cigarette companies from paying for product placement in films or hiring celebrity spokespeople; and (2) work through an appropriate federal process to prohibit e-cigarette advertising on television.

Resolution 930 asks that our American Medical Association (1) support legislation and US Food and Drug Administration (FDA) action to tax, label and regulate electronic nicotine delivery devices (ENDS) as tobacco

products and drug delivery devices; (2) support state and federal legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to the same restrictions as that of tobacco products; (3) support local, state, and national efforts to require transparency and disclosure concerning the design, content and emissions of ENDS; (4) support local, state, and national efforts to require secure, child-proof, tamper-proof packaging and design of ENDS; (5) support local, state, and national efforts to require enhanced labeling that warns of the potential consequences of ENDS use, restriction of ENDS marketing as tobacco cessation tools, and restriction of the use of characterizing flavors in ENDS; and (6) encourage basic, clinical, and epidemiological research concerning ENDS.

The Council was congratulated on its thorough investigation of the health effects of e-cigarettes, and general support for the report's recommendations was noted. Those testifying overwhelmingly spoke to the health dangers of e-cigarettes and their potential to reverse the substantial progress of efforts to reduce tobacco use over the last several decades. Of particular concern is the increasing use of e-cigarettes by adolescents and teens, which is likely partially driven by the use of flavors that are appealing to youth, and that often lead to the use of other tobacco products. Also noteworthy is the lack of evidence that e-cigarettes are efficacious as tobacco cessation tools. The authors of Resolutions 919, 927, and 930 testified that the Council report largely addresses the concerns in the resolutions. Your Reference Committee agrees, but believes that increased emphasis on prohibitions on the use of e-cigarettes in health care institutions, clarity on marketing restrictions, labeling and product standards for liquids used in e-cigarettes (e-liquids), and further research is called for in the recommendations. It therefore recommends that the Council's recommendations be amended accordingly, and adopted in lieu of Resolutions 919, 927, and 930.

(6) **RESOLUTION 901 - ADDRESSING EMERGING TRENDS IN RECREATIONAL DRUG ABUSE**

RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 901 be adopted.

ADDRESSING EMERGING TRENDS IN ILLICIT DRUG USE

RESOLVED, That our American Medical Association (AMA) support ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets and other educational materials; and be it further (New HOD Policy)

RESOLVED, That our AMA encourage the development of continuing medical education on emerging trends in illicit drug use; and be it further (Directive to Take Action)

RESOLVED, That our AMA support efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. (New HOD Policy)

HOD ACTION: Substitute Resolution 901 adopted.

Resolution 901 asks that our American Medical Association (1) support the appropriate agency to provide continuing medical education courses in emerging trends in recreational substance abuse; and (2) support the appropriate agency to disseminate current and accurate information regarding emerging trends in recreational substance abuse.

Testimony noted the fact that trends in illicit drug use and the design of new illicit substances continue to be a national problem. A need exists to monitor the development of so-called synthetic designer drugs and other psychoactive substances that may emerge for recreational use. Testimony noted that the National Institute on Drug

Abuse is developing an innovative National Drug Early Warning System to monitor emerging trends that will help health experts respond more efficiently to potential outbreaks of illicit drug use such as heroin, and to identify increased use of designer synthetic compounds. In addition, the Drug Enforcement Administration (DEA) annually publishes a “national drug threat assessment.” Both DEA and NIDA develop fact sheets and other educational materials related to substance misuse and Poison Control Centers can provide early warning signs. One problem in addressing illicit drug use is the need to place new compounds into Schedule I of the Controlled Substances Act, thereby making them illegal. Given that existing processes are in place to monitor emerging trends and to provide educational materials, your Reference Committee proposes a substitute resolution that reflects current activities. Relevant continuing medical education courses are better accomplished by health care professionals, not the federal government.

(7) RESOLUTION 903 - COMBATING SEX-LINKED DISCRIMINATION OF DENYING SPECIAL REQUEST FOR LACTATION DURING MEDICAL BOARD EXAMINATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 903 be adopted.

ACCOMMODATING LACTATING MOTHERS TAKING MEDICAL EXAMINATIONS

RESOLVED, That our American Medical Association urge all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give lactating mothers additional break time and a suitable environment during examinations to express milk. (New HOD Policy).

HOD ACTION: Substitute Resolution 903 adopted.

Resolution 903 asks that our American Medical Association (1) urge all medical examination agencies to grant special request to give breast feeding test-takers additional break time and a suitable environment during the medical licensing examination to express milk; and (2) encourage all medical examination agencies to serve as role models to improve public health by supporting mothers who provide breast milk to their infants.

Your Reference Committee heard testimony in strong support of Resolution 903, particularly as the percentage of female medical school matriculants continues to rise. Testimony was heard that the customary 45-minute break is frequently insufficient to allow for nursing mothers, who could experience engorgement and discomfort that could adversely affect examination performance. A less “combative” substitute title of the resolution was proposed by the authors, as well as revised language with increased specificity. Additional testimony was heard in support of these changes. Your Reference Committee is in accord with these suggestions and therefore recommends adoption of Substitute Resolution 903.

(8) RESOLUTION 904 - EQUAL PATERNAL AND MATERNAL LEAVE FOR MEDICAL RESIDENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-405.960 be amended by addition and deletion, to read as follows:

H-405.960 Policies for Parental Maternity, Paternity, Family and Medical Necessity Leave

AMA adopts as policy the following guidelines for, and encourage the implementation of, Parental Maternity, Family and Medical Necessity Leave for

Medical Students and Physicians: (1) Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement; (2) Recommended components of parental maternity leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption; and (j) leave policy for paternity. (3) AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental maternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental maternity leave policies a six-week minimum leave allowance, with the understanding that no parent woman should be required to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (7) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (8) Our AMA endorses the concept of equal parental paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity; (9) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (10) Physicians should be able to

return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; (11) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility; (12) Our AMA encourages flexibility in residency training programs, incorporating parental maternity leave and alternative schedules for pregnant house staff; and (13) In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-405.960 be adopted as amended in lieu of Resolution 904.

HOD ACTION: Policy H-405.960 adopted as amended in lieu of Resolution 904.

Resolution 904 asks that our AMA amend policy H-405.960 by insertion and deletion as follows:

H-405.960 Policies for Maternity, Paternity, Family and Medical Necessity Leave
AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement; (2) Recommended components of maternity and paternity leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption; and (j) leave policy for paternity. (3) AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking maternity and paternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity and paternity leave policies a six-week minimum leave allowance, with the understanding that no woman or man should be required to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (7) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance

benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (8) Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice equal to maternity leave benefits; (9) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (10) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; (11) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility; (12) Our AMA encourages flexibility in residency training programs, incorporating maternity and paternity leave and alternative schedules for pregnant house staff; (13) In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year; and (14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (Modify Current HOD Policy).

Your Reference Committee heard testimony in support of a proffered amendment to Resolution 904. This language, as shown above, both augments existing policy to include male parents, as encompassed in the original text, and replaces references to "maternity and paternity" with "parental," to reflect the multitudinous and diverse types of families today (as opposed to the traditional nuclear family). Rather than attempt to revise the original resolution, with numerous instances of added and redacted text, your Reference Committee recommends instead adoption of the proposed amended policy.

(9) RESOLUTION 906 - PERSONALIZED MEDICATION CARDS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 906 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association support third parties in researching the effectiveness of personalized medication cards and other tools intended to promote safe medication use, written in a variety of languages for low literacy target audiences, to achieve in increasing medication adherence and improving health outcomes. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 906 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 906 be changed to:

MEDICATION ADHERENCE IN PATIENTS WITH LOW HEALTH LITERACY

HOD ACTION: Resolution 906 adopted as amended with a title change.

Resolution 906 asks that our American Medical Association support third parties in researching the effectiveness of personalized medication cards, written in a variety of languages for low literacy target audiences, in increasing medication adherence and improving health outcomes.

Testimony noted current prevailing problems with medication non-adherence in the United States and the potential for personalized medication cards written in the patient's primary language, and at an appropriate literacy level, for improving medication adherence. The relationship between low health literacy and poor medication adherence is well established. Accordingly, support was expressed for addressing this issue in a culturally competent manner. Because many factors influence medication adherence and the ability of low-literacy patients to take prescribed medicines in a safe and effective manner, your Reference Committee recommends broadening the target for research to include other tools intended to promote safe medication use.

(10) RESOLUTION 908 - PROVIDING GREATER EMPHASIS ON THE SOCIAL DETERMINANTS OF HEALTH IN MEDICAL SCHOOL CURRICULUM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-295.874 be amended by addition and deletion, to read as follows:

H-295.874 Educating Medical Students in the Social Determinants of Health and for Cultural Competence: What do we know?

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence training across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models. (CME Rep. 11, A-06; Reaffirmation A-11.)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-295.874 be adopted as amended in lieu of Resolution 908.

HOD ACTION: Policy H-295.874 adopted as amended in lieu of Resolution 908.

Resolution 908 asks that our AMA support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations.

Your Reference Committee heard testimony that reaffirmation of current AMA policy was not adequate in this case, in that the social determinants of health is a broader term than cultural competence. It goes beyond race, ethnicity, and religion to encompass socioeconomic status, gender, and sexual orientation, among other aspects. Other testimony noted the AMA's traditional reluctance to dictate medical school curricula, and an existing accreditation standard of the Liaison Committee on Medical Education that already addresses this aspect of medical education. Accordingly, your Reference Committee recommends adoption of amended AMA policy in lieu of this resolution, to expand upon existing policy related to cultural competence.

(11) RESOLUTION 911 - USMLE STEP 1 TIMING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 911 be amended by addition and deletion on line 14 to read as follows:

RESOLVED, That our American Medical Association ask the appropriate stakeholders National Board of Medical Examiners to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance. (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 911 be adopted as amended.

HOD ACTION: Resolution 911 adopted as amended.

Resolution 911 calls for our American Medical Association to ask that the National Board of Medical Examiners track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance.

Your Reference Committee heard testimony that was largely in support of the principles expressed in Resolution 911. Currently, changes in the timing of USMLE Step 1 administration are under way at many medical schools nationwide. The innovations in medical education being developed and disseminated through the AMA's Accelerating Change in Medical Education initiative may have an impact on this issue as well, as the move from a time-based to a competency-based system of advancement begins to take root. Further study of the implications of the timing of Step 1 exams is warranted, although such study may be complex, and it may be challenging to evaluate causation. Testimony also stressed the need for a "competency-based examination" (to mirror competency-based medical education) and to ensure equity among medical students at different institutions. This is important because, although the examination's primary purpose is eligibility for medical licensure, it is also used for other purposes, including academic advancement and residency program placement. Finally, it was noted that the National Board of Medical Examiners may not be the appropriate body to undertake such study, so your Reference Committee recommends adoption as amended.

(12) RESOLUTION 917 - IMPROVE SAFETY OF MAIL-ORDERED MEDICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 917 be amended by addition and deletion on lines 19-24, to reads as follows:

RESOLVED, That our American Medical Association ~~work with appropriate agencies to support the establishment~~ of national guidelines for mail-order pharmacies to ensure that medications reach patients in a safe and timely manner with full potency; and that ~~the guidelines clarify it is the shipping pharmacy's responsibility to ensure safe shipment of when medication is damaged or loses potency during shipment, including it should be replaced~~ ~~medication by the pharmacy~~ at no cost to the patient if potency is affected during shipment by ~~inappropriate temperature exposure~~. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 917 be adopted as amended.

HOD ACTION: Resolution 917 adopted as amended.

Resolution 917 asks that our American Medical Association work with appropriate agencies to establish national guidelines for mail-order pharmacies to ensure that medications reach patients in a safe and timely manner with full potency; and that the guidelines clarify it is the shipping pharmacy's responsibility to ensure safe shipment of medication, including replacing medication at no cost to the patient if potency is affected during shipment by inappropriate temperature exposure.

Testimony noted that shipped medications may suffer damage due to temperature extremes. Simple technology exists to monitor temperature exposures during shipping. Accordingly, the shipping pharmacy should be responsible for ensuring the integrity of pharmaceutical product on delivery. State boards of pharmacy regulate mail order of medication and require licensure of the shipping pharmacy, and sometimes the pharmacist in charge of that pharmacy. Limited but fully supportive testimony was offered on this resolution. Your Reference Committee recommends amending the resolution to reflect the primary points of emphasis, and that other agencies and organizations have the primary responsibility for effecting change in this area.

(13) **RESOLUTION 918 - EXPANSION OF BOT 28-A-14 ON MEDICAL MANAGEMENT**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 918 be adopted.

MANAGEMENT AND LEADERSHIP FOR PHYSICIANS

RESOLVED, That our AMA study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with key stakeholders to advocate for collaborative programs between medical schools and related schools of business and management to better prepare physicians for administrative and leadership responsibilities in medical management. (Directive to Take Action)

HOD ACTION: Substitute Resolution 918 adopted.

Resolution 918 asks that our American Medical Association (1) study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; (2) as a member service, develop a guide aimed at physicians interested in management and leadership, that would include the advantages and disadvantages of various educational options and also develop a clearinghouse for educational programs that may aid physicians in enhancing their skills in management and leadership; and (3) encourage its Section on Medical Schools to advocate for joint programs between medical schools and related schools of business and management as formal pathways to better prepare physicians for administrative and leadership responsibilities in medical management.

Supportive testimony emphasized the importance of studying the educational options available to better prepare physicians for administrative and leadership responsibilities in medical management. There are a large number of management and leadership educational programs available to physicians, but their venues, geographic locations, and costs vary. This resolution calls on our AMA to determine the need to identify these programs and let physicians know the advantages and disadvantages of different types of programs (e.g., online vs. MBA programs, etc.), as well as to develop and host a clearinghouse of resources.

As part of its strategic plan to ensure professional satisfaction and practice sustainability, our AMA is currently assessing the need for physician leadership development programs to support its members and the nation's physicians. There was testimony against developing and hosting a clearinghouse due to the large fiscal note. The Reference Committee therefore recommends adoption of a substitute resolution to allow for further research and collaboration with key stakeholders to advocate for leadership programs.

(14) RESOLUTION 920 - COMBATING THE MEDICAL CERTIFICATION AND ITS ATTEMPT TO CAPTURE INTO UNPROVEN CERTIFICATION PROGRAMS WITH ITS REGULATIONS
 RESOLUTION 926 - MAINTENANCE OF CERTIFICATION
 RESOLUTION 928 - CANCELLATION OF MAINTENANCE OF CERTIFICATION
 RESOLUTION 929 - OPPOSITION OF MAINTENANCE OF CERTIFICATION AS A CONDITION FOR LICENSURE, CREDENTIALING, OR REIMBURSEMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 920 be adopted in lieu of Resolutions 920, 926, 928 and 929.

PRINCIPLES ON MAINTENANCE OF CERTIFICATION

RESOLVED, that our American Medical Association amend the Policy H-275.924, Principles on Maintenance of Certification (MOC), to include the following:

- 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.
- The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
- MOC should be used as a tool for continuous improvement.
- The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, or network participation, or employment.
- Actively practicing physicians should be well-represented on specialty boards developing MOC.
- MOC activities and measurement should be relevant to clinical practice.
- The MOC process should not be cost prohibitive or present barriers to patient care. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA encourage specialty boards to investigate and/or establish alternative approaches for MOC; (Directive to Take Action) and be it further

RESOLVED, That our AMA prepare a yearly report regarding the maintenance of certification process; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with the American Board of Medical Specialties to eliminate practice performance assessment modules, as currently written, from the requirement of MOC;

HOD ACTION: Substitute Resolution 920 adopted as amended in lieu of Resolutions 920, 926, 928 and 929, and the following proposed amendment to Policy H-275.924 referred:

Specialty boards, which develop MOC standards, may approve curriculum, but should be independent from entities designing and delivering that curriculum, and should have no financial interest in the process.

Resolution 920 asks that our American Medical Association release a yearly report regarding the maintenance of certification process.

Resolution 926 asks that our American Medical Association (1) amend the AMA Principles on Maintenance of Certification (AMA Policy H-275.924) to include the following:

- The MOC process should be designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care
- The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice
- Board certificates should have lifetime status, with MOC used as a tool for continuous improvement
- The MOC program should not be associated with hospital privileges, insurance reimbursements or network participation
- The MOC program should not be required for Maintenance of Licensure (MOL)
- Specialty boards, which develop MOC standards, may approve curriculum, but should be independent from entities designing and delivering that curriculum, and should have no financial interest in the process
- A majority of specialty board members who are involved with the MOC program should be actively practicing physicians directly engaged in patient care
- MOC activities and measurement should be relevant to real world clinical practice
- The MOC process should not be cost prohibitive or present barriers to patient care;

(2) work with the American Board of Medical Specialties to eliminate practice performance assessment modules, as currently written, from the requirements of MOC; (3) develop and disseminate a public statement, with concomitant direct notification to the American Board of Internal Medicine (ABIM), that their current ABIM MOC program has the appearance of being focused too heavily on enhancing ABIM revenues, and fails to provide a meaningful, evidence-based and accurate assessment of clinical skills (4) investigate and/or establish alternative pathways for MOC; and (5) report back to the House of Delegates at the 2015 Annual Meeting.

Resolution 928 asks that our American Medical Association strongly advocate for the cancellation of the current Maintenance of Certification (MOC) program and promote physician utilization of continuing medical education as currently required due to the overwhelming consensus of physicians that the current MOC program is ineffective, time-consuming, and economically burdensome.

Resolution 929 asks that our American Medical Association oppose maintenance of certification as a mandated requirement for licensure, credentialing, or reimbursement.

Your Reference Committee heard mixed testimony that included differences of opinion on this complex item. There was concern that the AMA not be perceived as being against the current processes that the medical profession has in place to maintain and improve the competence of physicians and to retain the public trust. There was also confusion about the details of MOC, especially regarding the relationship between MOC and MOL. Differences of opinion also appeared to be based on individual's experiences with their own specialty boards. Based on the testimony, it is clear that the issues of administrative burden, costs and relevance to practice need to be addressed, and that the Council on Medical Education, in subsequent reports, needs to be thorough about interpreting the evidence to show the efficacy of MOC in physician care and patient outcomes and encouraging increased financial transparency among the specialty boards. The Council on Medical Education has closely monitored the development and implementation of the MOC standards, and has reported back to the HOD annually since 2009. The reports have provided updates on AMA efforts with the American Board of Medical Specialties (ABMS) to improve MOC. Our AMA has been successful in shaping the ABMS standards on behalf of AMA membership as reflected in the 2015 standards. In June, our AMA in collaboration with the ABMS and nearly all of the ABMS member boards met to discuss the value of MOC Part III as well as practice relevant and innovative concepts that could potentially enhance or replace the current thinking around the secure, high-stakes exam requirement of MOC.

Our AMA has extensive policy to support the principles of MOC, and many of the issues raised in these resolutions are supported by current policy. For example, Policy H-297.932, Internal Medicine Board Certification Report--Interim Report, states that "Our AMA opposes the use of recertification or Maintenance of Certification (MOC) as a condition of employment, licensure or reimbursement." The Council on Medical Education will report back at A-15, and the report will include a review, update and consolidation of AMA policies on this topic, which includes the Principles on MOC that were originally adopted in 2009. Your Reference Committee therefore recommends that Substitute Resolution 920, which includes broad principles widely agreed upon, be adopted in lieu of Resolutions 920, 926, 928 and 929.

(15) RESOLUTION 922 - CHILD SAFETY SEATS-PUBLIC EDUCATION AND AWARENESS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 922 be amended by addition on line 18 to read as follows:

RESOLVED, That our American Medical Association support efforts to require child safety seat manufacturers to include information about the importance of rear-facing safety seats until children are two years of age or until they reach the maximum height or weight specifications of their car seat, at which time they should be placed in a forward-facing child safety system with a harness as recommended by the American Academy of Pediatrics. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 922 be adopted as amended.

HOD ACTION: Resolution 922 adopted as amended.

Resolution 922 asks that our American Medical Association support efforts to require child safety seat manufacturers to include information about the importance of rear-facing safety seats until two years of age as recommended by the American Academy of Pediatrics.

Your Reference Committee heard supportive testimony pertaining to child safety seat manufacturers, and their responsibility to include detailed instructions for safe use. The American Academy of Pediatrics offered a friendly amendment to the resolution, which further addressed the height and weight specifications. Your Reference Committee agreed with the amendment and subsequent supportive testimony. As such, your Reference Committee recommends Resolution 922 be adopted as amended.

(16) RESOLUTION 925 - EBOLA
 RESOLUTION 933 - EVIDENCE-BASED POLICY FOR HEALTH CARE
 WORKERS RETURNING FROM WEST AFRICA
 RESOLUTION 935 - AMA RESPONSE TO EPIDEMICS AND PANDEMICS
 RESOLUTION 936 - EVIDENCE-BASED POLICY FOR HEALTH CARE
 WORKERS RETURNING FROM WEST AFRICA

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 925 be adopted in lieu of Resolutions 925, 933, 935 and 936.

AMA ROLE IN ADDRESSING EPIDEMICS AND PANDEMICS

RESOLVED, That our American Medical Association (AMA) strongly support US and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries; (New HOD Policy) and be it further

RESOLVED, That our AMA strongly support those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, US Public Health Service and US military members; (New HOD Policy) and be it further

RESOLVED, That our AMA reaffirm Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science; (Reaffirm HOD Policy) and be it further

RESOLVED, That our AMA collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels; (Directive to Take Action) and be it further

RESOLVED, That our AMA continue to be a trusted source of information and education for physicians, health professionals and the public on; urgent epidemic or pandemics affecting the US population, such as Ebola; (Directive to Take Action) and be it further

RESOLVED, That the AMA encourage relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics. (New HOD Policy)

HOD ACTION: Substitute Resolution 925 adopted as amended in lieu of Resolutions 925, 933, 935 and 936.

Resolution 925 asks that our American Medical Association immediately convene an expedited expert consensus panel to make emergency recommendations on Ebola for the medical community and the general public and widely communicate those recommendations to the medical community and to the general public.

Resolution 933 asks that our American Medical Association (1) advocate for public health policies, such as contact monitoring, symptom monitoring and others, regarding asymptomatic healthcare workers and others returning from Ebola affected countries that are based on science and with the advice of experts in infectious diseases and public

health; (2) advocate for encouragement to those able and willing to volunteer for service in the care of patients with Ebola viral disease and recognize their willingness to serve; (3) discourage policies not based on science or evidence, such as enforced quarantine and others, that can discourage participation in service to Ebola victims and stigmatize healthcare workers that serve not only those in West Africa but those in the US by helping to control the disease where it is; and (4) support continued use of US resources in the fight against Ebola in West Africa.

Resolution 935 asks that our American Medical Association (1) provide regular updates in a timely manner on any disease classified by the World Health Organization as urgent epidemics or pandemics potentially affecting the US population; (2) work with the CDC and international health organizations to provide organizational assistance to curb epidemics, including calling on American physicians to provide needed resources such as human capital and patient care related supplies; and (3) encourage relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

Resolution 936 asks that our American Medical Association (1) reaffirm AMA Code of Medical Ethics Opinion 2.25; (2) advocate for public health policies, such as contact monitoring, symptom monitoring and others, regarding asymptomatic health care workers and others returning from Ebola affected countries that are based on science and with the advice of experts in infectious diseases and public health; (3) advocate for encouragement to those able and willing to volunteer for service in the care of patients with Ebola viral disease and recognize their willingness to serve; (4) discourage policies not based on science or evidence, such as enforced quarantine and others, that can discourage participation in service to Ebola victims and stigmatize health care workers that serve not only those in West Africa but those in the US by helping to control the disease where it is; and (5) support continued use of US military personnel and resources in the fight against Ebola in West Africa.

Extensive testimony addressed the importance of the global response to Ebola, the confusing and inconsistent response to treating those with Ebola, and quarantine procedures that are not based on evidence. Many were disappointed that the AMA's response to Ebola appeared to be delayed and not visible. Most believed that the AMA was not the right organization to take the lead role in developing guidelines for the medical community, but that it should represent physicians by collaborating in the development of such guidelines and widely disseminating them. A Board of Trustees member summarized many of the efforts in which the AMA has engaged, including the development of the Ebola Resource Center and the appearance of Dr. Wah on Face the Nation. Other testimony noted that this is a wake-up call for public health preparedness and that affected countries should be assisted in their efforts to improve their public health infrastructure. Given the number of resolutions received on this topic that cover overlapping issues, your Reference Committee recommends adoption of a substitute resolution stressing support for those working to fight Ebola in affected countries; quarantine and isolation procedures based on science; our AMA's role as an educator, collaborator and disseminator; and other specialty societies' efforts to develop resources on epidemics and pandemics.

Policy recommended for reaffirmation:

E-2.25 The Use of Quarantine and Isolation as Public Health Interventions

Quarantine and isolation to protect the population's health potentially conflict with the individual rights of liberty and self-determination. The medical profession, in collaboration with public health colleagues, must take an active role in ensuring that those interventions are based on science and are applied according to certain ethical considerations. (1) To this end, the medical profession should: (a) seek an appropriate balance of public needs and individual restraints so that quarantine and isolation use the least restrictive measures available that will minimize negative effects on the community through disease control while providing protections for individual rights; (b) help ensure that quarantine and isolation are based upon valid science and do not arbitrarily target socioeconomic, racial, or ethnic groups; (c) advocate for the highest possible level of confidentiality of personal health information whenever clinical information is transmitted in the context of public health reporting; (d) advocate for access to public health services to ensure timely detection of risks and prevent undue delays in the implementation of quarantine and isolation; (e) help to educate patients and the public about quarantine and isolation through the development of educational materials and participation in educational programs; (f) advocate for the availability of protective and preventive measures for physicians and others caring for patients with communicable diseases. (2) Individual physicians should participate in the implementation of appropriate quarantine and isolation measures as part of their obligation to provide medical care during epidemics (see Opinion E-9.067, "Physician Obligation in Disaster Preparedness and Response"). In

doing so, advocacy for their individual patients' best interests remains paramount (see Opinion E-10.015, "The Patient-Physician Relationship"). Accordingly, physicians should: (a) encourage patients to adhere voluntarily to scientifically grounded quarantine and isolation measures by educating them about the nature of the threat to public health, the potential harm that it poses to the patient and others, and the personal and public benefits to be derived from quarantine or isolation. If the patient fails to comply voluntarily with such measures, the physician should support mandatory quarantine and isolation for the non-compliant patient; (b) comply with mandatory reporting requirements and inform patients of such reports; (c) minimize the risk of transmitting infectious diseases from physician to patient and ensure that they remain available to provide necessary medical services by using appropriate protective and preventive measures, seeking medical evaluation and treatment if they suspect themselves to be infected, and adhering to mandated public health measures. (3) Frontline physicians have an increased ethical obligation to avail themselves of safe and effective protective and preventive measures (for example, influenza vaccine). (I, III, VI, VII, VIII) Issued June 2006 based on the report "The Use of Quarantine and Isolation as Public Health Interventions," adopted November 2005.

(17) RESOLUTION 932 - APPEAL TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION TO RELEASE FULL FUNDING FOR THE NAVAJO BIRTH COHORT STUDY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 932 be amended by addition and deletion on page 2, lines 1-4 to read as follows:

RESOLVED, That our American Medical Association recognize the public health importance of the Navajo Birth Cohort Study for our Native American population and other populations exposed to uranium. (New HOD Policy); and be it further

~~RESOLVED, That our AMA work with key stakeholders the Congressional delegations of New Mexico and other interested states and parties involved with the Navajo Birth Cohort Study, to set up an urgent, high level meeting with strongly urge Congress and the Centers for Disease Control and Prevention to discuss restore full to advocate for appropriate funding of to the NBCS as mandated by Congress. (Directive to Take Action)~~

RESOLVED, That our AMA urgently endeavor to convene key stakeholders involved with the Navajo Birth Cohort Study and appropriate high-level officials of the Centers for Disease Control and Prevention, with the goal of achieving a resolution of any issues that have prevented the release of full funding to the university contracted to perform this study, as mandated by Congress. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 932 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 932 be changed to read as follows:

NAVAJO BIRTH COHORT STUDY

HOD ACTION: Resolution 932 adopted as amended with a title change.

Resolution 932 asks that our American Medical Association (1) recognize the public health importance of the Navajo Birth Cohort Study for our Native American population and other populations exposed to uranium; and (2) work with the Congressional delegations of New Mexico and other interested states and parties involved with the Navajo Birth Cohort Study, to set up an urgent, high-level meeting with the Centers for Disease Control and Prevention to discuss full funding of the NBCS as mandated by Congress.

Limited but supportive testimony noted the importance of the Navajo Birth Cohort Study in determining effects of uranium exposure on pregnant women and young children. Your Reference Committee agrees that the AMA should recognize the public health importance of the Navajo Birth Cohort Study for our Native American population and other populations exposed to uranium. Your Reference Committee recommends amending the second resolve to allow flexibility in the approach to urging funding of the study.

(18) RESOLUTION 907 - PROMOTING EDUCATION OF ELECTRONIC
HEALTH RECORDS IN UNDERGRADUATE MEDICAL EDUCATION
RESOLUTION 914 - EXCESSIVE COMPUTER TIME FOR MEDICAL
STUDENTS, RESIDENTS AND FELLOWS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 907 and 914 be referred.

HOD ACTION: Resolutions 907 and 914 referred.

Resolution 907 asks that our American Medical Association support efforts to incorporate electronic health records training into undergraduate medical education.

Resolution 914 asks that our American Medical Association work with the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach trainees in those programs effective methods of utilizing electronic devices in the exam room and at the bedside, so that they enhance rather than impede the physician-patient relationship, so as to have a positive impact on said relationship and healthcare for the patient.

Your Reference Committee heard testimony in support of these resolutions. EHRs are becoming an important and growing part of health care, and formal educational training in EHRs during medical school will help build a structure and will enhance the ability of future physicians to navigate the systems seamlessly. There was testimony against adoption of these resolutions because curriculum development should be the purview of medical schools; it is not appropriate for our AMA to impose specific curricular mandates. The AMA Council on Medical Education recognizes the importance of medical student access to EHRs and is currently working on its second report on this topic for the A-15 HOD Meeting. The report will look at EHR characteristics that would mitigate compliance, liability and other concerns, e.g., learning to use the EHR in a way to enhance patient interviewing, and showcase some innovative training models. Your Reference Committee believes that the planned Council report would be the best method by which to fully examine meaningful access to and training on EHRs in undergraduate and graduate medical education and ensure effective AMA policy on this critical issue. Therefore your Reference Committee recommends referral.

(19) RESOLUTION 931 - PRIVATE PAYER FUNDING OF GRADUATE
MEDICAL EDUCATION

Mr. Speaker, your Reference Committee recommends that Resolution 931 be referred.

HOD ACTION: Resolution 931 referred.

Resolution 931 asks that our American Medical Association (1) encourage and advocate for private and alternative sources of funding for GME educational opportunities; (2) support when appropriate and advocate for additional sources of funding for private payers to support both direct and indirect costs of graduate medical education and explore funding for additional residency slots; and (3) encourage state and specialty societies to seek private and alternative sources of funding for state-specific graduate medical educational opportunities.

Resolution 931 seeks to extend AMA policy on graduate medical education funding (GME) to include support of additional private sources of funding for expansion of GME positions. Testimony was mixed; both support for the resolution and support for referral were evident. Existing AMA policy supports maintaining and expanding Medicare and Medicaid GME funding levels and advocates for contributions by all payers of health care (including the federal government, states, and private insurers) to fund GME. However, private funding may be extremely variable and could include both private foundations and industry. While strong support was expressed for expanding GME positions and the all payer model, some concerns remain about the potential influences of private industry on trainees. For these reasons and based on the complexity of this issue, your Reference Committee believes this issue warrants further study and recommends referral.

(20) RESOLUTION 934 - CREATION OF AMA PRINCIPLES FOR PHYSICIAN DEMONSTRATION OF CURRENT PROFESSIONAL EXPERTISE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 934 be referred.

HOD ACTION: Resolution 934 referred.

Resolution 934 asks that our American Medical Association adopt the following Principles on Maintenance of Licensure (MOL) as a resource and make them available to state medical societies that seek guidance in determining MOL Principles for their states: 1. The AMA supports continuous lifelong learning by physicians and quality improvement in the practice of medicine and will only support implementation of MOL requirements when substantial and convincing evidence demonstrates that such requirements will improve clinical outcomes/patient care. 2. That in the event that substantial and convincing evidence exists that such MOL requirements will improve clinical outcomes/patient care, and implementation of these requirements moves forward, the AMA will support the following: a. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment. b. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based, and should be specialty specific. Accountability for physicians should be led by physicians. c. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physician's time and the impact on patient access to care, as well as a risk/benefit analysis with particular attention to unintended consequences. d. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education). e. Any MOL activity should be designed for quality improvement and lifelong learning. f. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity. 3. The AMA shall work in collaboration with state and specialty medical societies and state agencies responsible for establishing criteria for MOL regarding any continuing medical education and lifelong learning. The physician community must be involved with the discussions and final deliberations before enactment. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 934. There was concern with the first resolve setting unrealistic expectations. There also was confusion about MOC being a requirement for MOL. Currently the guiding principles of MOL, adopted by the Federation of State Medical Boards, recognize the value of active engagement in meeting MOC requirements. MOC is not intended to become a mandatory requirement for medical licensure but should be recognized as meeting some or all of a state's requirements for MOL to avoid unnecessary duplication of work. The Council on Medical Education has closely monitored the development of the principles of MOL, and has reported back to the HOD annually since 2009. The Council is preparing a report for A-15 on this topic. Due to the complexity of the issues raised in this Resolution and the need for additional study, your Reference Committee recommends referral of Resolution 934.

(21) RESOLUTION 923 - TRANSPARENCY OF PHARMACEUTICAL
MANUFACTURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 923 not
be adopted.

HOD ACTION: Resolution 923 not adopted.

Resolution 923 asks that our American Medical Association (1) study the pharmaceutical manufacturing and advocate to improve monitoring of the manufacturing and finished product in countries supplying drugs to the US; and (2) advocate for including the source country of the active pharmaceutical ingredients and of the manufacture of the finished drugs on the labels of all medications available to American consumers until such time as US monitoring and foreign manufacturing are deemed adequate.

Testimony reflected concerns about the integrity of pharmaceutical products and/or their active pharmaceutical ingredients that may either be produced in foreign manufacturing facilities or imported from foreign countries. These concerns have been heightened by some recalls of generic products made in India, China, and other countries. All drugs approved in the United States, regardless of where they are made, must be in compliance with the Federal Food, Drug, and Cosmetic Act, which requires that drugs meet manufacturing standards to assure quality and product label requirements. Manufacturing standards are the same for brand-name and generic drugs. In fact, many brand-name drugs are produced overseas as well, often in the same plants as the generic equivalents.

Your Reference Committee is aware that in 2012, Congress passed the FDA Safety and Innovation Act, which, among other things, requires the agency to inspect foreign facilities that make drugs sold in the US as frequently as it does at domestic plants. The number of foreign inspections by the FDA is expected to grow at a faster rate in FY 2015 than the increase in domestic inspections.

Some concerns were raised with this resolution. The AMA does not have the resources or capacity to study foreign drug manufacturing. Some support was offered for referral or reaffirmation of current policy, which supports: (1) the inspection of all foreign drug manufacturers who export drug products to the United States to assure compliance with US standards; (2) periodic surveillance inspections of all foreign pharmaceutical manufacturers with timely follow-up inspection of those manufacturers that have been identified as having serious manufacturing deficiencies; and, (3) urging Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients. Additionally, given the fact that about 40 percent of the medications Americans use daily are made outside the US, and 80 percent of all active drug ingredients used to make medications taken in the US come from other countries, adding this information to product labeling would appear to provide little actionable value for American consumers. Your Reference Committee therefore recommends that this resolution not be adopted.