MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

Mary J. Hudak, MD
Introduced by Pennsylvania

Whereas, Mary J. Hudak, MD, was born March 17, 1953 in Pittsburgh, Pennsylvania and passed away on December 30, 2013 in York, Pennsylvania following an extended illness; and

Whereas, Dr. Hudak was a graduate of the University of Pittsburgh and earned her MD degree from the Medical College of Pennsylvania in 1978; and

Whereas, Dr. Hudak completed her residency in Internal Medicine at York Hospital; practiced medicine in York County for over 20 years, several of those years in private practice before joining Gotham Internal Medicine as a hospitalist; and served as Medical Director of Palliative Care at York Hospital; and

Whereas, Dr. Hudak was a member of the Pennsylvania Medical Society (PAMED) and the York County Medical Society (YCMS) from 1984 until her passing; and

Whereas, In 1991, Dr. Hudak was elected to the YCMS Board of Directors; served as YCMS Secretary in 1993 and also from 1998 until 2012; was elected as YCMS Vice President in 1994 and ascended to President Elect in 1995 and President in 1996; served as a delegate to the PAMED House from 1993 to 2012; served on the PAMPAC Board from 1997 until 2002 and was Chair of the PAMPAC Board in 2001 and 2002; and

Whereas, Dr. Hudak was a member of our American Medical Association from 1986 to 2012; and

Whereas, Dr. Hudak served as a member of our AMA House of Delegates as an alternate delegate from 1994 to 2001 and a delegate from 2002 to 2007; and

Whereas, Dr. Hudak strongly believed in advocating for physicians and their patients, as reflected by her commitment to organized medicine; and

Whereas, Dr. Hudak and her husband of 33 years, F. John Waldron, shared a love of animals, Phillies baseball, Eagles football and Flyers hockey; and

Whereas, Dr. Hudak will be greatly missed, both as a physician and a friend; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions of Mary J. Hudak, MD, to her profession and to organized medicine; and be it further

RESOLVED, That a copy of this resolution be recorded in the Proceedings of the 2014 Interim Meeting of the AMA House of Delegates and be forwarded to her family with an expression of the House's deepest sympathy.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, November 9. The following resolutions were handled on the reaffirmation calendar: 5, 203, 603, 802, 806, 816, 823, 905, 913 and 921.

1. ADVANCE DIRECTIVES DURING PREGNANCY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support that pregnant women with decision-making capacity have the same right to refusal of treatment through advance directives as nonpregnant women; and be it further

RESOLVED, That our AMA further study the legality and ethics related to the circumstances under which restrictions and/or exclusions are applied to pregnant women's advance directives.

2. PROTECTING MEDICAL STUDENTS' RIGHTS AS PATIENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED
See Policy H-315.983.

RESOLVED, That our American Medical Association amend Policy H-315.983 by insertion and deletion to read as follows:

H-315.983 Patient Privacy and Confidentiality
(1) Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. (2) Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. (3) Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, ~~and~~ physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in

an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. (5) The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. (6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. (7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. (8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. (9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. (10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. (11) Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures (12) Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. (13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. (14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. (15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. (16) The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. (17) Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. (18) Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. (19) Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. (20) Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

3. SOLITARY CONFINEMENT OF JUVENILES IN LEGAL CUSTODY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy H-60.922.

RESOLVED, That our American Medical Association oppose the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances such as the protection of the juvenile, staff, or other detainees; and be it further

RESOLVED, That our AMA oppose the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and be it further

RESOLVED, That our AMA support that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

4. LEGAL PROTECTION AND SOCIAL SERVICES FOR COMMERCIALLY SEXUALLY EXPLOITED YOUTH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-60.969.

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 services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth.

5. OPT-OUT ORGAN DONATION
Introduced by Wisconsin

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-370.966 AND D-370.985 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study the utility and ethics of different organ donation consent policies, including opt-out (presumed consent) organ donation with the goal of improving organ donation rates.

6. PHYSICIAN CIVIL DISCOURSE
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-405.958.

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.

7. DELEGATE COUNTS FOR RFS ASSEMBLY MEETINGS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED
See Policy D-615.979.

RESOLVED, That a new category of representatives to the AMA-RFS Assembly Meeting be established for At-Large Delegates who serve in approved training programs, to be selected pursuant to uniform rules and criteria adopted by the RFS Governing Council and approved by the Board of Trustees. At-Large Delegate representation shall be 10% of the average number of registered RFS delegates and alternate delegates from the previous year; and be it further

RESOLVED, That a new category of representatives to the AMA-RFS Assembly Meeting be established to allow each National Resident and Fellow Organization that has been granted representation in the Resident and Fellow Section to select one representative and one alternate representative. National Resident and Fellow Organizations that meet the following criteria may be considered for representation in the AMA-RFS Assembly Meeting by the Governing Council:

i. The organization must be national in scope.
ii. The organization must be composed solely of residents or fellows who participate in ACGME accredited residency or fellowship.
iii. Membership in the organization must be available to all residents or fellows, without discrimination.
iv. The purpose and objectives of the organization must be consistent with the AMA's purpose and objectives.
v. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics; and be it further

RESOLVED, That our AMA amend the provision in Bylaw 7.1.3.2 allowing resident/fellow physicians to be selected as representatives to the AMA-RFS Assembly Meeting upon application to the RFS Governing Council to instead allow representatives to attend even if a state medical society does not provide full membership. The AMA shall inform each state medical society that does not provide full membership for resident/fellow physicians how many delegate positions are available on the basis of one representative for each 100, or fraction thereof, direct members of the AMA from that state who are resident/fellow physicians; and be it further

RESOLVED, That our American Medical Association modify Bylaw 7.1.3.3 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 be it further

RESOLVED, That our AMA eliminate the provision in Bylaw 7.1.3.4 requiring national medical societies who desire to participate in the AMA-RFS Assembly Meeting of the Resident and Fellow Section to have established a resident/fellow physician membership component. The AMA shall allow national medical specialty societies represented in the AMA House of Delegates to select one representative and one alternative representative for every

100, or fraction thereof, who are resident/fellow members. The AMA shall notify each national medical specialty society of the number of representatives to which it is entitled; and be it further

RESOLVED, 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, resident and fellow members. The AMA shall notify each professional interest medical association of the number of representatives to which it is entitled.

8. ENSURING ACCESS TO HEALTH CARE, MENTAL HEALTH CARE, LEGAL AND SOCIAL SERVICES FOR UNACCOMPANIED MINORS AND OTHER RECENTLY IMMIGRATED CHILDREN AND YOUTH
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-60.968.

RESOLVED, That our American Medical Association work with medical societies and all clinicians to 1) 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 2) secure federal, state and other funding sources to support those services.

9. THE AMA MUST PROCLAIM ITS SUPPORT FOR HEALTH CARE FOR ALL, REGARDLESS OF AGE
Introduced by Gregory L. Pinto, MD, Delegate, New York

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association issue a statement publicly disagreeing with the sentiments expressed by Dr. Emanuel in his article in *The Atlantic* (September 17, 2014); and be it further

RESOLVED, That our AMA issue a statement proclaiming its Code of Ethics as the basis for disagreeing with Dr. Emanuel's expressed opinions in his recent article in *The Atlantic* (September 17, 2014):

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people [without regard to age]; and be it further

RESOLVED, That our AMA urge the AMA Foundation to make clear to all award recipients that the bestowing of an award does not mean that our AMA endorses every position espoused by the award recipient; and be it further

RESOLVED, That our AMA urge the AMA Foundation to rescind the Isaac Hays, MD, and James Bell, MD, Award for Leadership in Medical Ethics and Professionalism it bestowed on Dr. Emanuel.

201. SHORT-TERM URGENT REFILLS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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; and be it further

RESOLVED, That our AMA generate model state legislation to allow short-term urgent refills for certain critical medications as often as once a month.

202. SOBRIETY CHECKPOINTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-15.990.

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

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

203. INCLUSION OF PREVENTIVE MEDICINE PHYSICIANS IN THE NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM
Introduced by Medical Student Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES D-200.978, D-305.974, D-305.975 AND D-305.982 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the inclusion of physicians trained in preventive medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program.

204. ICD-10 AND COST OF CODING CHANGES
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-70.951.

RESOLVED, 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.

205. JUVENILE JUSTICE SYSTEM REFORM
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

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; and be it further

RESOLVED, 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; 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.

206. HELP CONTROL PHARMACEUTICAL COSTS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-330.954.

RESOLVED, That our American Medical Association work toward eliminating Medicare prohibition on drug price negotiation.

207. GENERIC PHARMACEUTICAL PRICING
Introduced by Idaho

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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.

208. STARK LAW AND PHYSICIAN COMPENSATION
Introduced by Utah

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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.

209. EXPANSION OF SAFE DRUG DISPOSAL SITES
Introduced by Utah

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-135.936.

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; and be it further

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

210. FLORIDA
Introduced by AMA Promotion of Improved Electronic Health Records

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-478.982.

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

211. CPR TRAINING
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 212
See Policy H-130.938.

RESOLVED, That our American Medical Association support legislation that would encourage high school students be trained in cardiopulmonary resuscitation.

212. CPR TRAINING AS A HIGH SCHOOL GRADUATION REQUIREMENT
Introduced by American College of Cardiology

Resolution 212 considered with Resolution 211. See Resolution 211.

RESOLVED, That our American Medical Association 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.

213. CANNABIS – EXPANDED AMA ADVOCACY
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-95.976.

RESOLVED, That our American Medical Association immediately educate the media and legislators as to the health effects of cannabis use as elucidated in Council on Science and Public Health Reports 3-I-09 and 2-I-13; and be it further

RESOLVED, That our AMA urge legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research; and be it further

RESOLVED, 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; and be it further

RESOLVED, That our AMA 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."

214. PAIN MEDICINE
Introduced by South Carolina

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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 and Medicaid Services (CMS) from using pain scores as part of CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and be it further

RESOLVED, That our AMA request that CMS educate the public about the real risk of narcotic use and patient responsibility; and be it further

RESOLVED, 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; and be it further

RESOLVED, 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; and be it further

RESOLVED, 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.

215. PREAUTHORIZATION
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION 215 ADOPTED IN LIEU OF RESOLUTIONS 219, 221 AND 222
See Policies H-320.950 and D-320.988.

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 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 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.

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

216. SITE OF SERVICE PAYMENT DISCREPANCIES
Introduced by College of American Pathologists, American Society for Clinical Pathology, American Society of Cytopathology, National Association of Medical Examiners, United States and Canadian Academy of Pathology and American Society of Anesthesiologists

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-400.957 AND H-400.969 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, 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.

217. POWDERED CAFFEINE AND EASY UNINTENTIONAL OVERDOSE
Introduced by Thomas Madejski, MD, Delegate, New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-150.973.

RESOLVED, That our American Medical Association seek regulation or legislation to ban the sale of powdered caffeine to minors; and be it further

RESOLVED, 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.

218. PARITY OF PAYMENT FOR ADMINISTRATION OF MEDICATIONS WITHIN THE SAME CATEGORY OF DRUG
Introduced by American College of Rheumatology, American Academy of Allergy, Asthma and Immunology and American Gastroenterological Association

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association use its influence and resources to secure Congressional outreach to the Centers for Medicare and Medicaid Services (CMS) with the objective that CMS issue guidance requiring parity of payment for administration of medications within the same category of drug.

219. OPPOSITION TO INSURANCE COMPANY POLICIES THAT INTERFERE WITH APPROPRIATE OUTPATIENT LABORATORY SERVICES
Introduced by American College of Rheumatology, American Academy of Allergy, Asthma and Immunology, American Society of Hematology, American Association of Clinical Endocrinologists, American Congress of Obstetricians and Gynecologists, The Endocrine Society and American College of Physicians

Resolution 219 was considered with Resolutions 215, 221 and 222. See Resolution 215.

RESOLVED, 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.

220. PROTECTING PATIENTS' ACCESS TO PRESCRIPTION DRUGS
Introduced by Hawaii

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, 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.

221. REMOVING BARRIERS TO PAYMENTS FOR VACCINE AND MEDICATION ADMINISTRATION
Introduced by Pennsylvania

Resolution 221 was considered with Resolutions 215, 219 and 222. See Resolution 215.

RESOLVED, 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.

222. QUANTIFYING THE BURDEN OF PRIOR AUTHORIZATION
Introduced by Organized Medical Staff Section

Resolution 222 was considered with Resolutions 215, 219 and 221. See Resolution 215.

RESOLVED, 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.

223. PRESERVATION OF SMALL MEDICAL PRACTICES
Introduced by Georgia

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-478.991, D-405.988 AND E-9.02 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, 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.

224. TRANSPARENCY AND LABELING OF GENERIC MEDICATIONS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-125.984 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, 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.

225. PHYSICIAN CREDIT CARD PAYMENTS BY HEALTH INSURANCE COMPANIES
Introduced by Virginia, South Carolina, West Virginia

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-190.972.

RESOLVED, 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.

226. EXTENSION OF DEADLINE TO FILE CLAIM FOR FICA TAX REFUND
Introduced by Virginia, South Carolina, West Virginia

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association investigate the number of unclaimed FICA tax refunds by medical residents; and be it further

RESOLVED, 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.

227. 2015 MEDICARE PHYSICIAN FEE SCHEDULE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association convene/host a series of discussions about the 2015 Medicare Physician Fee Schedule among all concerned specialty societies; and be it further

RESOLVED, That our AMA appeal to the Centers for Medicare & Medicaid Services (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; and be it further

RESOLVED, That our AMA report back to the House of Delegates as soon as possible, preferably by the 2015 Annual Meeting.

228. HIGH COST OF DRUGS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

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

RESOLVED, That our AMA explore the rapidly escalating cost of generic drugs that are years past developmental costs; and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2015 Annual Meeting.

229. PREVENTING DRUG MANUFACTURERS FROM RESTRICTING THEIR DISTRIBUTION NETWORKS
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-110.992, H-110.998 AND D-110.993 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, 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; and be it further

RESOLVED, 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; and be it further

RESOLVED, 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.

230. AMA SUPPORT OF THE PREVENTIVE HEALTH SAVINGS ACT
Introduced by American College of Preventive Medicine and American College of Occupational and Environmental Medicine

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY D-155.994 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, 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.

601. EMPLOYEE ASSOCIATIONS AND COLLECTIVE BARGAINING FOR PHYSICIANS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED
See Policy D-383.981.

RESOLVED, That our American Medical Association study and report back on physician unionization in the United States.

RESOLUTION 602 WAS NOT CONSIDERED.

603. CRITICAL CONGENITAL HEART DISEASE SCREENING PROCEDURE CODE
Introduced by Utah

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-70.919 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association request proposals to the CPT Editorial Panel to create a CPT screening procedure code for routine Critical Congenital Heart Disease screening of newborns by non-physician nursery staff at birth facilities.

604. AMA-PROVIDED INNOVATION GRANTS TO SUPPORT NEW PHYSICIAN MODELS TO IMPROVE QUALITY, EFFICIENCY AND REDUCE COST
Introduced by Maryland

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop innovation grants to explore new ways to improve quality and efficiency, and reduce cost in all medical practice settings, including independent private practice.

605. HELPING TO BETTER INFORM LEGISLATORS ON MEDICAL MATTERS
Introduced by Maryland

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED
See Policy G-640.045.

RESOLVED, That our American Medical Association inform members of Congress and their staff that AMA Morning Rounds is available through our website to the public without charge.

606. CREATION OF THE AMA SUPER PAC
Introduced by Georgia

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association create and provide significant initial and ongoing funding for a new subsidiary, the AMA Super PAC, to participate in independent expenditures for or against candidates for federal office; and be it further

RESOLVED, That the AMA Super PAC only support candidates that have already been endorsed by AMPAC at the recommendation of state medical society PACs; and be it further

RESOLVED, That the AMA Board of Trustees determine the structure, organizing principles, name, membership and terms of office of the Organizing Board of Directors of the AMA Super PAC; and be it further

RESOLVED, That the AMA Board of Trustees determine the amount of money to be dedicated to the AMA Super PAC annually; and be it further

RESOLVED, That the AMA Super PAC Board of Directors be responsible for determining the allocation of monies for independent expenditures, actively participate in all operational decisions regarding the independent expenditures and develop a plan to encourage contributions from other entities eligible to contribute to our Super PAC for the purposes of advancing the AMA's agenda for our patients and our profession; and be it further

RESOLVED, That the AMA Board of Trustees report back at the 2015 Annual Meeting with recommendations for the new AMA Super PAC.

607. STUDY THE LONGER-TERM EFFECTS OF PHYSICIAN EMPLOYMENT
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED
See Policy D-225.976.

RESOLVED, That our American Medical Association 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?

801. PATIENT ACCESS TO PENILE PROSTHESIS AS LEGITIMATE TREATMENT FOR ERECTILE DYSFUNCTION
Introduced by American Urological Association and American Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-185.933.

RESOLVED, That our American Medical Association work in concert 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.

802. ADVOCATING FOR RESEARCH ON PHYSICIAN-INITIATED CONVERSATIONS ABOUT TREATMENT COST
Introduced by Medical Student Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-373.997, H-373.998 AND H-450.938 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the conduction of controlled studies to determine if conversations about cost with patients have any meaningful change on various measures of health outcomes, including but not limited to quality of treatment decisions, liability, and patient satisfaction; and be it further

RESOLVED, That our AMA support studies to determine if physicians or health professionals are the appropriate party to initiate such conversations.

803. EMERGENCY DEPARTMENT INSURANCE LINKING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-185.934.

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.

RESOLUTION 804 WAS NOT CONSIDERED.

805. INCORPORATING COMMUNITY HEALTH WORKERS INTO THE US HEALTH CARE SYSTEM
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA support appropriate stakeholders to define community health workers in order to define their required level of training and scope of practice and to legitimize their role as health care providers.

806. INTERNATIONAL IN-FLIGHT MEDICAL EMERGENCY CENTER
Introduced by Indiana

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-45.978 AND H-45.979 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support a study on the practicality, utility and cost of establishing an international in-flight medical emergency center and report the results to airlines and other vested parties; and be it further

RESOLVED, That our AMA develop a policy supporting the establishment of an international in-flight medical emergency center if proven to be effective and affordable.

807. MEDICAL EMERGENCY ALGORITHMS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association 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.
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.

808. ACCESS TO PSYCHIATRIC SERVICES
Introduced by Vidya Kora, MD, Delegate, Indiana

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: POLICIES H-345.978, H-345.981, H-385.921 AND D-345.997 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for improving access to psychiatric services by improving reimbursement; and be it further

RESOLVED, That our AMA develop a policy that the reimbursement for psychiatric services for Medicaid patients be increased to Medicare levels; and it be further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA 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.

809. INSURANCE COVERAGE FOR FERTILITY PRESERVATION IN PATIENTS RECEIVING CYTOTOXIC OR IMMUNOMODULATORY AGENTS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-185.990.

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 ~~oncologic~~ medical treatments 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 ~~oncologic~~ medical treatments as determined by a licensed physician.

810. PATIENT EDUCATION REGARDING THE MEDICARE CHRONIC CARE MANAGEMENT FEE
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED
See Policy D-160.929.

RESOLVED That our American Medical Association create a model letter that its members may use to explain the Medicare chronic care management fee to their patients.

811. HEALTH PLAN COVERAGE FOR OUTPATIENT OBESITY PRIMARY CARE VISITS
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-440.954.

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).

812. HEALTH PLAN COVERAGE FOR HEARING AID DEVICES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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.

813. MEDICAID ENHANCED RATES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association work with other medical organizations, including the American College of Physicians, the American Academy of Pediatrics, the American Academy of Family Physicians and the American Congress of Obstetricians and Gynecologists, 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.

814. SCIP AND HCAHPS MEASURES USED BY CMS IN HOSPITAL REIMBURSEMENT
Introduced by Utah

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: POLICIES H-450.946, H-450.966 AND D-385.958 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services (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.

815. BOARD RECERTIFICATION TO MAINTAIN HOSPITAL STAFF PRIVILEGES
Introduced by Alabama

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-230.986.

RESOLVED, That our American Medical Association update model hospital staff bylaws to address the problem of requiring board recertification to remain on staff; and be it further

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.

RESOLVED, That once our AMA develops these model hospital staff bylaw changes with regards to board recertification then they should be made public in our AMA publications so physicians will recognize this problem of losing staff privileges that may be upon us in the near future.

816. BURDENSOME IMPACT OF MEDICARE'S FACE-TO-FACE FORM REQUIREMENTS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-330.909 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association undertake a study to determine the burden and impact on a physician's practice of the face-to-face form requirements.

817. MEDICARE COVERAGE OF HEARING AIDS
Introduced by Florida

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support Medicare coverage of hearing aid devices, including external and implantable hearing aid devices.

818. ACCESS AND EQUITY IN TELEMEDICINE PAYMENTS
Introduced by Iowa, Nebraska, North Dakota and South Dakota

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-480.970.

RESOLVED, The our American Medical Association advocate that the Centers for Medicare and Medicaid Services (CMS) 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.

819. PRICE TRANSPARENCY
Introduced by Iowa, Nebraska, North Dakota and South Dakota

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association: 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 and 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.

820. ANTITRUST ACTIVITY
Introduced by Florida

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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.

821. REVIEW OF STRADDLE DRUG PRICING RULES FOR MEDICARE PART D PARTICIPANTS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-120.943.

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; 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.

RESOLUTION 822 WAS REASSIGNED AS RESOLUTION 222.

823. MEDICARE COVERAGE OF VACCINES DURING OFFICE VISITS
Introduced by Oregon

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-440.860 AND H-440.875 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association request the Centers for Medicare and Medicaid Services cover routine preventative Tdap and Herpes Zoster vaccines along with any Advisory Committee on Immunization Practices (ACIP) recommended preventive immunization during an office visit.

824. VACCINES TO MEDICARE PATIENTS
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy H-440.875.

RESOLVED, That until compliance of American Medical Association Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, 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" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients; and be it further

RESOLVED, 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 health clinical guidelines.

825. PRINCIPLES FOR HOSPITAL SPONSORED ELECTRONIC HEALTH RECORDS
Introduced by California

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association continue to urge Congress and the Centers for Medicare and Medicaid Services (CMS) to mandate that all electronic health record (EHR) systems be interoperable; and be it further

RESOLVED, That our AMA urge Congress and CMS 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, and that our AMA advocate and communicate these principles to the hospital community:

1. A hospital or other sponsoring entity providing a subsidized EHR platform to a physician or medical group must provide an interoperable system for the physicians and medical groups treating patients in that hospital.
2. Physicians or medical groups entering into a subsidized EHR agreement with a hospital must maintain ownership and control of its patient data, including but not limited to demographic information, quality, cost and utilization data.
3. Hospitals are prohibited from requiring physicians or medical groups to surrender their rights to own, control and access their patient data when entering into a donated or subsidized EHR agreement with the hospital.
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 between the hospital and the physician or medical group.
5. In the event a subsidized EHR agreement between a physician/medical group and a hospital is subsequently 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.
6. Hospitals or other entities providing sponsored EHR must participate in regional health information exchanges when they become available to achieve meaningful use.

826. NON-FORMULARY MEDICATIONS AND THE MEDICARE PART D COVERAGE GAP
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED
See Policy H-125.977.

RESOLVED, That our American Medical Association 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, after which coverage resumes; and be it further

RESOLVED, That our AMA advocate for economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.

827. CARE COORDINATION
Introduced by David Tayloe, Jr., MD, Delegate, American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-385.963.

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 that they need to assure optimal outcomes; and be it further

RESOLVED, That our AMA with work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.

901. ADDRESSING EMERGING TRENDS IN ILLICIT DRUG ABUSE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-95.940.

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

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

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.

RESOLUTION 902 WAS NOT CONSIDERED.

903. ACCOMMODATING LACTATING MOTHERS TAKING MEDICAL EXAMINATIONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-295.861.

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.

904. EQUAL PATERNAL AND MATERNAL LEAVE FOR MEDICAL RESIDENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: POLICY H-405.960 AMENDED
IN LIEU OF FOLLOWING RESOLUTION

Policy H-405.960 amended by addition and deletion to read as follows:

H-405.960 Policies for ~~Maternity, Paternity~~ Parental, Family and Medical Necessity Leave
AMA adopts as policy the following guidelines for, and encourage the implementation of ~~Maternity~~ Parental, 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~~ parental 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~~ parental leave without the loss of status; (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their ~~maternity~~ parental leave policies a six-week minimum leave allowance, with the understanding that no ~~woman~~ parent 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 ~~maternity~~ parental 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.

905. INCREASING HEALTHY FOOD CHOICES AMONG FAMILIES SUPPORTED BY THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
Introduced by Medical Student Section

Considered on reaffirmation calendar.

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

RESOLVED, That our American Medical Association advocate for positive financial incentives to encourage healthier food purchases for Supplemental Nutrition Assistance Program participants.

906. MEDICATION ADHERENCE IN PATIENTS WITH LOW HEALTH LITERACY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy H-373.993.

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 increased medication adherence and improved health outcomes.

907. PROMOTING EDUCATION OF ELECTRONIC HEALTH RECORDS IN UNDERGRADUATE MEDICAL EDUCATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support efforts to incorporate electronic health records training into undergraduate medical education.

908. PROVIDING GREATER EMPHASIS ON THE SOCIAL DETERMINANTS OF HEALTH IN MEDICAL SCHOOL CURRICULUM
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

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

Policy H-295.874 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.

RESOLUTION 909 WAS NOT CONSIDERED.

RESOLUTION 910 WAS NOT CONSIDERED.

911. USMLE STEP 1 TIMING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-275.958.

RESOLVED, That our American Medical Association ask the appropriate stakeholders 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.

RESOLUTION 912 WAS NOT CONSIDERED.

913. DIETARY SUPPLEMENT DANGERS
Introduced by Wisconsin

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-150.954 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support efforts to educate physicians on: (1) the facts regarding the mislabeling, contamination, and adulteration of dietary supplements; (2) evidence regarding the safety and efficacy of most dietary supplements; and (3) how to access current reliable sources of information about dietary supplements; and be it further

RESOLVED, That our AMA develop policy that physicians could serve their patients better by knowing about the lobbying efforts of the dietary supplement industry that aim to prevent any increase in the US Food and Drug Administration's (FDA) ability to oversee the industry, and about the Dietary Supplement Health and Education Act of 1994 which severely weakened the FDA's ability to regulate dietary supplements; and be it further

RESOLVED, That our AMA support efforts to give the FDA powers and funding to effectively oversee the manufacturing, marketing, and sale of dietary supplements.

914. EXCESSIVE COMPUTER TIME FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education 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.

RESOLUTION 915 WAS NOT CONSIDERED.

RESOLUTION 916 WAS NOT CONSIDERED.

917. IMPROVE SAFETY OF MAIL-ORDERED MEDICATION
Introduced by Utah

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-120.936.

RESOLVED, That our American Medical Association 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 when medication is damaged or loses potency during shipment, it should be replaced by the pharmacy at no cost to the patient.

918. MANAGEMENT AND LEADERSHIP FOR PHYSICIANS
Introduced by American Medical Group Association

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-295.316.

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; 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.

919. PROHIBIT E-CIGARETTES IN HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS
Introduced by American College of Cardiology

Resolution 919 was considered with Council on Science and Public Health Report 2.
See Council on Science and Public Health Report 2.

RESOLVED, 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.

920. PRINCIPLES ON MAINTENANCE OF CERTIFICATION
Introduced by Florida

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION 920 ADOPTED
IN LIEU OF RESOLUTIONS 926, 928 AND 929
PROPOSED AMENDMENT TO POLICY H-275.924 REFERRED
See Policies H-275.924 and D-275.960.

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

11. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
12. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
13. MOC should be used as a tool for continuous improvement.
14. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment.
15. Actively practicing physicians should be well-represented on specialty boards developing MOC.
16. MOC activities and measurement should be relevant to clinical practice.
17. The MOC process should not be cost prohibitive or present barriers to patient care.

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

RESOLVED, That our AMA prepare a yearly report regarding the maintenance of certification process; 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.

[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.

921. A TOBACCO FREE MILITARY
Introduced by New Jersey

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-490.913 AND H-495.986 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association strongly support that all of the military forces in and of the United States be tobacco-free zones; and be it further

RESOLVED, That our AMA advocate that all cigarette sales in military installations be removed and cease to exist; and be it further

RESOLVED, That our AMA advocate that educational smoking-cessation programs be elaborated upon and widely offered upon the enlistment of military service people, particularly during the smoke-free basic training periods.

922. CHILD SAFETY SEATS - PUBLIC EDUCATION AND AWARENESS
Introduced by Maryland

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-15.950.

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.

923. TRANSPARENCY OF PHARMACEUTICAL MANUFACTURE
Introduced by Maryland

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association study the pharmaceutical manufacturing and advocate to improve monitoring of the manufacturing and finished product in countries supplying drugs to the US; and be it further

RESOLVED, That our AMA advocate for including the source country of the manufacture of the active pharmaceutical ingredients if other than in the US and of the manufacture of the finished pill if other than in the US on the labels of all medications available to American consumers until such time as US monitoring and foreign manufacturing are deemed adequate.

RESOLUTION 924 WAS WITHDRAWN

925. AMA ROLE IN ADDRESSING EPIDEMICS AND PANDEMICS
Introduced by California

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION 925 ADOPTED IN LIEU OF RESOLUTIONS 933, 935 AND 936
See Policies H-440.835 and E-2.25.

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; 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; 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; 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; 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 epidemics or pandemics affecting the US population, such as Ebola; 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.

926. MAINTENANCE OF CERTIFICATION
Introduced by Pennsylvania

Resolution 926 was considered with Resolutions 920, 928 and 929. See Resolution 920.

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

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA investigate and/or establish alternative pathways for MOC; and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2015 Annual Meeting.

927. E-CIGARETTE ADVERTISING AND PAID PRODUCT PLACEMENT
Introduced by Pennsylvania

Resolution 927 was considered with Council on Science and Public Health Report 2.
See Council on Science and Public Health Report 2.

RESOLVED, That our American Medical Association work through an appropriate federal process to prohibit e-cigarette companies from paying for product placement in films or hiring celebrity spokespeople; and be it further

RESOLVED, That our AMA work through an appropriate federal process to prohibit e-cigarette advertising on television.

928. CANCELLATION OF MAINTENANCE OF CERTIFICATION
Introduced by Georgia

Resolution 928 was considered with Resolutions 920, 926 and 929. See Resolution 920.

RESOLVED, 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.

929. OPPOSITION OF MAINTENANCE OF CERTIFICATION AS CONDITION FOR LICENSURE, CREDENTIALING OR REIMBURSEMENT
Introduced by Virginia, South Carolina, West Virginia, Kentucky

Resolution 929 was considered with Resolutions 920, 926 and 928. See Resolution 920.

RESOLVED, That our American Medical Association oppose maintenance of certification as a mandated requirement for licensure, credentialing or reimbursement.

930. REGULATION OF ELECTRONIC NICOTINE DELIVERY DEVICES
Introduced by Virginia, South Carolina, West Virginia, Kentucky

Resolution 930 was considered with Council on Science and Public Health Report 2.
See Council on Science and Public Health Report 2.

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

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA support local, state, and national efforts to require transparency and disclosure concerning the design, content and emissions of ENDS; and be it further

RESOLVED, That our AMA support local, state, and national efforts to require secure, child-proof, tamper-proof packaging and design of ENDS; and be it further

RESOLVED, That our AMA support local, state, and national efforts to require enhanced labelling 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 be it further.

RESOLVED, That our AMA encourage basic, clinical, and epidemiological research concerning ENDS.

931. PRIVATE PAYER FUNDING OF GRADUATE MEDICAL EDUCATION
Introduced by Virginia, South Carolina, West Virginia, Kentucky

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association encourage and advocate for private and alternative sources of funding for GME educational opportunities; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA encourage state and specialty societies to seek private and alternative sources of funding for state-specific graduate medical educational opportunities.

932. APPEAL TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION TO RELEASE FULL FUNDING FOR THE NAVAJO BIRTH COHORT STUDY
Introduced by New Mexico

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-460.969.

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; and be it further

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.

933. EVIDENCE-BASED POLICY FOR HEALTH CARE WORKERS RETURNING FROM WEST AFRICA
Introduced by Organized Medical Staff Section

Resolution 933 was considered with Resolutions 925, 935 and 936. See Resolution 925.

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

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA support continued use of US resources in the fight against Ebola in West Africa.

934. CREATION OF AMA PRINCIPLES FOR PHYSICIAN DEMONSTRATION OF CURRENT PROFESSIONAL EXPERTISE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: REFERRED

RESOLVED, 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.

935. AMA RESPONSE TO EPIDEMICS AND PANDEMICS
Introduced by Resident and Fellow Section

Resolution 935 was considered with Resolutions 925, 933 and 936. See Resolution 925.

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

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA encourage relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

936. EVIDENCE-BASED POLICY FOR HEALTH CARE WORKERS RETURNING FROM WEST AFRICA
Introduced by Colorado

Resolution 936 was considered with Resolutions 925, 933 and 935. See Resolution 925.

RESOLVED, That our American Medical Association reaffirm AMA Code of Medical Ethics Opinion 2.25; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA support continued use of US military personnel and resources in the fight against Ebola in West Africa.