

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

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

(1) BOARD OF TRUSTEES REPORT 11 - SPECIALTY SOCIETY
REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR
REVIEW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 11 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 11 adopted and the remainder of the report filed.

Board of Trustees Report 11 recommends that the American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Abdominal Surgeons, Heart Rhythm Society, National Association of Medical Examiners and the Triological Society retain representation in the American Medical Association House of Delegates.

The Board of Trustees introduced this report and there was no further testimony. Your Reference Committee recommends that Board of Trustees Report 11 be adopted.

(2) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 -
AMENDMENTS TO THE BYLAWS OF THE ACADEMIC PHYSICIANS
SECTION (FORMERLY THE SECTION ON MEDICAL SCHOOLS)

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

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 1 adopted and the remainder of the report filed.

Council on Constitution and Bylaws Report 1 recommends renaming of the American Medical Association Section on Medical Schools (AMA-SPS) to the American Medical Association Academic Physicians Section (AMA-APS). The report also recommends that the section 7.2.3 Representatives to the Business Meeting is reformatted and absorbed into section 7.2.1 Academic Physicians Section. Finally, the report recommends that only physicians who are AMA members may participate in the Section's Business Meeting.

Testimony for this report was strongly in favor of adoption. The recommendations of the report were universally lauded for their inclusiveness in welcoming more members of the medical community into this section, especially for community physicians who are part-time faculty and may have been excluded previously. Although there was limited testimony suggesting that the requirements for membership were ambiguous, the reference committee reviewed this information and found the language and recommendations within the report to be clear. Therefore, your Reference Committee recommends that Council on Constitution and Bylaws Report 1 be adopted.

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

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 2 referred and the remainder of the report filed.

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

Testimony in support of this report was mixed, with many calling for referral. Those in favor of the report's adoption spoke specifically about the use of samples in communities that are medically underserved and disproportionately burdened by health care disparities. Yet, those opposed to adoption stated that the report too severely limits the ability of small practices to dispense samples, while others found the recommendation restricting the provision of samples only within the confines of an established patient-physician relationship to be unrealistic and impractical. Upon further review of the report and its recommendations, members of the reference committee found that the testimony in opposition to the adoption of the report is inconsistent with the actual ethical guidance contained therein. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be adopted.

(4) **BOARD OF TRUSTEES REPORT 9 - ADVANCE DIRECTIVES DURING PREGNANCY**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 9 be amended by addition of a fourth recommendation to read as follows:

4. That our American Medical Association recognize that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 9 be amended by addition of a fifth recommendation to read as follows:

5. That the Council on Ethical and Judicial Affairs consider examining the issue of advance directives in pregnancy through an informational report.

RECOMMENDATION C:

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

HOD ACTION: Recommendations in Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

Board of Trustees Report 9 presents the current laws regarding advance directives during pregnancy as they differ by state and addresses the ethical issues such as a woman's right to autonomy. According to the report, many state laws refuse to honor the wishes of pregnant women as outlined in their advance directives. This report recommends that in lieu of Resolution 1-I-14, that our AMA vigorously affirm the centrality of the patient-physician relationship,

reaffirm AMA policy that promotes the use of advance directives to govern treatment decisions for all patients, and promote the awareness of physicians to advance care planning.

Testimony was strongly in favor of this report, and in particular, acknowledged the critical importance of recognizing the autonomous decisions of women in their end-of-life decision making regardless of their pregnancy status. Supporters of the report discussed the need for more women to have advance directives in place, and that physicians can play an increasingly important role in reminding women to update their advance directives accordingly depending on their respective health statuses. Suggestions for additional language were offered. Specifically, it was recommended that the report include language for the consideration of an ethical review and appeal process for specific situations where clinical complexities may make decision-making by the family and the clinical team especially difficult. Other testimony recommended that the Council on Ethical and Judicial Affairs examine this topic through an informational report. Your Reference Committee recommends that Board of Trustees Report 9 be adopted as amended.

(5) RESOLUTION 3 - MEDICAL STUDENTS AND RESIDENTS AS PATIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 3 be amended by addition and deletion on lines 23-25 to read as follows:

RESOLVED, That our American Medical Association study ways to address the power-dichotomy between physicians and medical students, ~~residents and fellows~~ as it relates to these trainees' care as patients.

RECOMMENDATION B:

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

HOD ACTION: Resolution 3 adopted as amended.

Resolution 3 addresses the issue of medical students and residents seeking care at institutions involved as training centers for their programs. The resolution raises concerns of an asymmetric power dynamic existing between physicians and medical students/residents, as well as potential problems regarding privacy, and asks that our AMA study this power relationship as it relates to the trainees' care as patients.

Those who testified unanimously agreed that there is a power imbalance between trainees and the physicians with whom they work. The resolution calls for studying this imbalance, yet the consensus seemed to be that it is not the imbalanced relationship that needs studying, but rather how to address this imbalance so that trainees can receive care appropriately and fairly. Your Reference Committee agrees with this sentiment and therefore amended the language of the resolve clause, and recommends adoption as amended.

(6) RESOLUTION 5 - MEDICAL NEEDS OF UNACCOMPANIED, UNDOCUMENTED IMMIGRANT CHILDREN

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children ~~from Central America~~ without proper documentation ~~status that are part of the 2013 2014 surge at the U.S. border~~ is ~~an urgent~~ humanitarian issue ;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that that Resolution 5 be amended by deletion of the third resolve:

~~RESOLVED, That our AMA acknowledge that returning unaccompanied children without proper documentation to their country of origin could pose potential health risks ; and be it further~~

RECOMMENDATION C:

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

HOD ACTION: Resolution 5 adopted as amended.

Resolution 5 describes the unprecedented surge of unaccompanied children from Central America seeking entrance to the United States that continues to rise exponentially. It asks that our AMA immediately release an official statement acknowledging the physical, mental, and psychological health of these unaccompanied minors, to meet and work with physician specialty societies to identify obstacles to proper health care, and to consider legislation to address these issues.

Testimony was unanimously in favor of this resolution. Those testifying acknowledged that this is an ongoing humanitarian issue that does not just affect the southern borders and has not been limited to the years indicated in the resolution. However, while the first, second, fourth and fifth resolves discuss ways in which our AMA can help these children and otherwise address the issue, the third resolve takes a political stance that is not a matter of domestic public health policy. Therefore, your Reference Committee recommends that Resolution 5 be adopted as amended.

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

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

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

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

Testimony for this report was mixed, with many praising the work already done by the Council on Ethical and Judicial Affairs on the topic of telemedicine. Those speaking in favor of the report praised its timeliness given the rapidly changing technological landscape in medicine and the increasing use of telemedicine to address issues of health care access throughout the country. Much of this positive testimony acknowledged how the current report falls in line with the existing telemedicine guidelines of other bodies, and that the ethical guidance offered is important for protecting patients. Other testimony, however, stated that the report should be referred for additional consideration by CEJA. Testimony calling for referral highlighted concerns about the tone and tenor of the report, stating that the existing language does not clearly address the issue of medical liability within telemedicine and that the ethical expectations outlined by the report may not be practical in certain clinical contexts and scenarios. In particular, radiologists or pathologists may not be able to fulfill recommendations (a) or (c). Finally, it was suggested the CEJA clarify that state and specialty societies can articulate guidelines that go beyond those contained

with the report, and that the role of the report is to serve as guidance. Overall, your Reference Committee Recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

(8) RESOLUTION 6 - IOM “DYING IN AMERICA” REPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 6 be referred for decision.

HOD ACTION: Resolution 6 referred for report back at A-16.

Resolution 6 speaks to the serious issues around end-of-life care in the United States, and the work conducted and published by the Institute of Medicine in its 2014 report “Dying in America.” Based on the findings and recommendations of the IOM report, this resolution asks that our AMA advocate for the coverage of the provision of comprehensive care for individuals with advance serious illness who are nearing the end of life; that our AMA work with specialty and other organizations to develop standards for physician-patient communication and advance care planning; that our AMA work with the ACGME and other organizations to establish appropriate training and certification requirements to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness who are nearing the end of life; that our AMA encourage the integration of financing of medical and social services to support the provision of quality care consistent with the values, goals, and informed preferences of people with advanced serious illness nearing the end of life; that our AMA ask the federal government to publicly report on quality measures, outcomes and costs regarding care within the last year of life within the Medicare, Medicaid and Department of Veterans Affairs; that our AMA work collaboratively with other organizations to provide fact-based information about care of people with advanced serious illness in order to encourage advance care planning and informed choice; and that our AMA oppose linking training in providing care to patients with advanced serious illness to licensure.

Testimony for this resolution was predominately in favor of referral. While many who testified spoke in favor of the spirit of the report given the incredible amount of work that needs to be done around end-of-life decision making in the medical field, there was palpable skepticism about the content and recommendations of the IOM report. Testimony noted that the report had not been fully vetted by the AMA, and that there were incongruencies between different versions of the report as well as the report’s summary. In particular, IOM guidance within the report discussing the tying of palliative care education with a physician’s licensure was met with disapproval. Finally, it was noted the endorsing a report in its entirety could have unintended consequences for the AMA. Your Reference Committee recommends Resolution 6 be referred for decision.

(9) RESOLUTION 7 - REMOVING DISINCENTIVES AND STUDYING THE USE OF INCENTIVES TO INCREASE THE NATIONAL ORGAN DONOR POOL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies E-2.152 and D-370.985 be reaffirmed in lieu of Resolution 7.

HOD ACTION: Resolution 7 be adopted.

Resolution 7 asks that our AMA support the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation. Furthermore, the resolution asks that our AMA support well-designed studies investigating the use of incentives, including valuable considerations, to increase living and cadaveric organ donation rates and that our AMA seek the necessary legislation to remove the legal barriers to conducting this form of research.

Testimony for this resolution was unanimously in favor of its adoption. Those testifying spoke about the desperate need for organs by thousands of people in the United States, with many offering their own personal accounts of

seeing how the current organ shortage harms patients. Despite overwhelming support for the resolution, the reference committee notes that existing AMA policy stands firmly against the commodification of organs as outlined in E-2.152, Solicitation of the Public for Directed Donation of Organs for Transplantation (“Directed donation policies that produce a net gain of organs in the organ pool and do not unreasonably disadvantage others on the waiting list are ethically acceptable, as long as donors receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation”), and that AMA policy already encourages the study of alternative methods for increasing the US organ donor pool in D-370.985, Methods to Increase the US Organ Donor Pool (“Our AMA will study potential models for increasing the United States organ donor pool”). Therefore, your Reference Committee recommends that Policies E-2.152 and D-370.985 be reaffirmed in lieu of Resolution 7.

REPORT OF REFERENCE COMMITTEE ON *CODE* MODERNIZATION

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

RECOMMENDATION:

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

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

As the Council on Ethical and Judicial Affairs has previously reported, in 2008 it began a project to comprehensively review the AMA's foundational document, the *Code of Medical Ethics*, and update the Opinions that interpret AMA Principles of Medical Ethics. The Council's goal was to ensure that the *Code*'s ethical guidance keeps pace with the demands of a changing world of medical practice. This project represents the first such thoroughgoing review in more than 50 years.

With assistance from the Federation of Medicine and AMA Councils and Sections, the Council reviewed each individual Opinion for clarity, timeliness and ongoing relevance in today's health care environment, and consistency within the *Code*. The Council reorganized Opinions into a more intuitive chapter structure to ensure that guidance is easy to find and adopted a uniform format for Opinions to ensure that guidance is easy to read and easy to apply. In modernizing Opinions, the Council looked for opportunities to consolidate guidance into a single, comprehensive statement on a topic; to harmonize guidance on related issues; and to identify and update or retire guidance that has become significantly outdated over time. Throughout, the Council strove to preserve the accumulated wisdom of the House of Delegates represented in the Opinions of the *Code*.

Your Reference Committee heard testimony on this item in chapter order, beginning with the Preface and concluding with general comments about the modernized *Code*. No testimony specific to the language of the Preface and Preamble was offered. Testimony was offered on a limited number of draft opinions in chapters 3, 4, 6, 7, 9, and 11. Significant concerns were raised about several draft opinions in chapters 2A, 2B, 5, 8, and 10. In many instances, testimony addressed matters outside the scope of this hearing in raising concerns about existing guidance. In these instances and in an effort to aid the Council in future considerations pertaining to the *Code*, your Reference Committee has asked staff to provide detailed notes to the Council in order to clarify these items.

Your Reference Committee heard testimony strongly encouraging the Council to reexamine existing guidance on physician-assisted suicide in light of recent developments in California and elsewhere.

Testimony repeatedly raised concern about the need to be clear that the modernized *Code* provides guidance, not regulation. Your Reference Committee believes the following content in the Preface addresses this concern:

The Council recognizes that circumstances at times impinge on physicians' ability or opportunity to follow the guidance of the *Code* strictly as written. Recognizing when such circumstances exist and determining how best to adhere to the goals and spirit, if not the absolute letter, of guidance requires physicians to use skills of ethical discernment and reflection. Physicians are expected to have compelling reasons to deviate from guidance when, in their best judgment, they determine it is ethically appropriate or even necessary to do so.

Concerns raised in testimony suggest to your Reference Committee that a glossary or similar resource would help in interpreting guidance. Testimony also indicated that technical problems regarding access to the draft modernized *Code* prevented thorough review. Your Reference Committee requests that the *Code* be made more accessible in the future. www.ama-assn.org/go/cejaforum

Multiple comments expressed concern about the process by which this draft modernized *Code* has been brought to the House of Delegates. Your Speakers are examining ways to improve this process going forward.

Testimony indicated some confusion about the scope of *Code* modernization. Your Reference Committee wishes to clarify that this project addresses only opinions of the Council on Ethical and Judicial Affairs. The AMA *Principles*

of Medical Ethics (www.ama-assn.org/go/Code), with their existing preamble, remain separate from the project and have not been revised.

Your Reference Committee commends the tireless efforts of the current and former members of the Council to update the *Code*, as well as the thoughtful and impassioned efforts of previous Reference Committees and the House of Delegates to provide further clarity to the items therein. Your Reference Committee particularly appreciates the testimony provided at this meeting, as this input has brought our AMA much closer to consensus on a modernized *Code*. While your Reference Committee heard considerable testimony in favor of the modernized *Code*, several points of contention persist. After careful consideration, your Reference Committee concluded that it is within the best interest of our AMA to ask the Council to make further clarifications to the *Code* in order to better represent the collective spirit of the Federation of Medicine. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

REPORT OF REFERENCE COMMITTEE B

(1) RESOLUTION 209 - PROTECTING SOCIAL MEDIA USERS BY UPDATING FDA GUIDELINES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 209 be adopted.

HOD ACTION: Resolution 209 adopted.

Resolution 209 asks that our American Medical Association lobby the Food and Drug Administration (FDA) to update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media , and lobby the FDA to develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.

Your Reference Committee heard unanimous support for Resolution 209 and therefore recommends adoption.

(2) BOARD REPORT 5 - PAIN MEDICINE

RECOMMENDATION A:

Madam Speaker, Your Reference Committee recommends that Board of Trustees Report 5 be amended by addition of a second recommendation to read as follows:

2. That our American Medical Association (AMA) continue to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); and

RECOMMENDATION B:

Madam Speaker, Your Reference Committee recommends that Board of Trustees Report 5 be amended by addition of a third recommendation to read as follows:

3. That our AMA continue to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and

RECOMMENDATION C:

Madam Speaker, Your Reference Committee recommends that Board of Trustees Report 5 be amended by addition of a fourth recommendation to read as follows:

4. That our AMA encourage hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain; and

RECOMMENDATION D:

Madam Speaker, Your Reference Committee recommends that Board of Trustees Report 5 by adopted as amended and the remainder of the report be filed.

RECOMMENDATION E:

Madam Speaker, Your Reference Committee recommends that Policy D-450.962 be amended by addition to read as follows:

D-450.962 Pain Management and the Hospital Value-Based Purchasing Program

1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS and Emergency Department Patient Experience of Care (ED-PEC)) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain.
2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.

RECOMMENDATION F:

Madam Speaker, Your Reference Committee recommends that Policy D-450.962 be adopted as amended.

HOD ACTION: Recommendations in Board of Trustees Report 5 adopted as amended and the remainder of the report filed. Policy D-450.962 adopted as amended.

The Board of Trustees Report 5 recommends our AMA reaffirm Policy D-450.962, “Pain Management and the Hospital Value-Based Purchasing Program,” Policy H-185.931, Policy H-95.945, “Prescription Drug Diversion, Misuse and Addiction,” Policy H-95.946, “Prescription Drug Monitoring Program Confidentiality,” Policy H-95.947, “Prescription Drug Monitoring to Prevent Abuse of Controlled Substances,” Policy H-95.990, “Drug Abuse Related to Prescribing Practices,” and Policy D-95.981, “Improving Medical Practice and Patient/Family.”

Your Reference Committee commends our AMA Board of Trustees for writing an excellent report. Your Reference Committee, however, agrees with the majority of those testifying that the recommendation in Board of Trustees Report 5 would benefit from additional recommendations to help guide our AMA advocacy. The issues raised in testimony related to both Hospital Consumer Assessment of Health Care Providers and Systems surveys, as well as Emergency Department Patient Experience of Care surveys are critical and timely, especially as they relate to evaluation of pain management programs. We appreciate our Board of Trustees agreeing with the proposed additional recommendations. As a result, your Reference Committee recommends that Board of Trustees Report 5 be adopted as amended and that amended Policy D-450.962 be adopted.

(3) BOT REPORT 6 - STARK LAW AND PHYSICIAN COMPENSATION

RECOMMENDATION A:

Madam Speaker, Your Reference Committee recommends that the Recommendation in Board of Trustees Report 6 be amended by addition and deletion to read as follows:

That our American Medical Association opposes and continues to advocate against the misuse of the Stark Law and regulations to unfairly and arbitrarily cap or control physician compensation.

RECOMMENDATION B:

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

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

The Board of Trustees Report 6 recommends that Substitute Resolution 208-I-14 be adopted and the remainder of the report be filed.

Testimony on Board Report 6 was favorable but asked for additional action language to accomplish the original resolution's objectives. An amendment was offered to pursue modifications of the Stark Law and regulations. As the Board Report noted, the crux of the problem is the misuse and misinterpretation of the fair market value benchmark to artificially degrade physician compensation, as opposed to the statutory and regulatory parameters of fair market value per se. As such, a focused and strategic advocacy campaign building upon our AMA's current efforts and policies regarding physician compensation is best suited to achieving the desired ends. Based on this testimony and the information presented in Board Report 6, your Reference Committee recommends that the Recommendation in Board Report 6 be adopted as amended.

(4) BOT REPORT 8 - HEALTH CARE ENTITY CONSOLIDATION

RECOMMENDATION A:

Madam Speaker, Your Reference Committee recommends that the Recommendation in Board of Trustees Report 8 be amended by addition to read as follows:

The Board of Trustees recommends that Resolution 820-I-14 be adopted as amended to read as follows:

RESOLVED, That our American Medical Association (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 8 be adopted as amended, and that the remainder of the report be filed.

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

The Board of Trustees Report 8 recommends that Resolution 820-I-1 be adopted and that the remainder of this report be filed.

Testimony on Board Report 8 was favorable but asked for additional language to enhance the resolution's scope. A friendly amendment was offered to ensure that potentially monopolistic activity is scrutinized and challenged at the outset, before a formal determination has been made by the relevant authorities that a violation of antitrust law has already occurred. In light of this testimony, your Reference Committee recommends that the Recommendation in Board of Trustees Report 8 be adopted as amended and the remainder of the report be filed.

(5) RESOLUTION 202 - MAINTAINING FREEDOM OF CHOICE WITH INSURANCE PRODUCTS
 RESOLUTION 217 - HEALTH INSURANCE COMPANY CONSOLIDATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Substitute Resolution 202 be adopted in lieu of Resolution 217.

RESOLVED, That our AMA oppose consolidation in the health insurance industry that may result in anticompetitive markets.

HOD ACTION: Substitute Resolution 202 adopted in lieu of Resolution 217.

Resolution 202 asks that our American Medical Association review and ensure that the proposed mergers by the multi-state insurers comply with all relevant statutes and regulations. . Resolution 217 asks that our AMA visibly (publicly) make substantial efforts to stop further consolidation of health insurance companies until careful examination by the antitrust divisions of the Federal Trade Commission and the Attorney General offices of the U.S. and each of the 50 states, of the consolidation of the health insurance industry in the last 5 to 10 years; and that the results of such inquiries be reported to the AMA House of Delegates no later than 2017.

Your Reference Committee heard highly supportive testimony on Resolutions 202 and 217. Testimony was presented that consolidation among health insurance companies is undermining physicians' negotiating power and compromising their ability to advocate for patients. Testimony indicated widespread concern that health insurance markets are already highly concentrated and that further consolidation would continue this trend, to the detriment of physician practices and patient care. Testimony also noted that the proposed health insurance mergers could exacerbate the problem of narrow networks and imperil patients' access to care.

Both resolutions align with current AMA efforts. Our AMA has been extensively involved in advocacy activities related to the proposed mergers between large health insurers, to include testifying twice before the U.S. House of Representatives Judiciary Committee, meeting with the U.S. Senate Judiciary Committee and the U.S. Department of Justice (DOJ) Antitrust Division, and sending a letter to DOJ asking the Agency to block the mergers. Given this ongoing advocacy and the overlap of Resolutions 202 and 217, your Reference Committee recommends that the two resolutions be reconciled through a substitute resolution establishing AMA policy in opposition to further consolidation within the health insurance industry that could result in or exacerbate concentrated markets, which are detrimental to healthy competition and patient care. As such, your Reference Committee urges that Substitute Resolution 202 be adopted in lieu of Resolutions 202 and 217.

(6) RESOLUTION 208 - ADDRESSING SEXUAL VIOLENCE AND IMPROVING AMERICAN INDIAN AND ALASKA NATIVE WOMEN'S HEALTH OUTCOMES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA will (1) advocate for mitigation of the critical issues of American Indian/Alaska Native women's health ~~by: (1) lobbying the Senate Committee on Indian Affairs and appropriate authorities to resolve the logistical and jurisdictional issues~~ that place Native women at increased risk for sexual violence; and (2) encouraging allocation of sufficient~~significant~~ resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA collaborate with the Indian Health Service, Centers for Disease Control, Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals, residents, and medical students about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population; and be it further

RECOMMENDATION C:

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

HOD ACTION: Resolution 208 adopted as amended.

Resolution 208 asks that our American Medical Association advocate for the critical issues of American Indian/Alaska Native women's health by: (1) lobbying the Senate Committee on Indian Affairs and appropriate authorities to resolve the logistical and jurisdictional issues that place Native women at increased risk for sexual violence; and (2) encouraging allocation of significant resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women ; collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians, residents, and medical students about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population ; and collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian and Alaska Native women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes.

Your Reference Committee heard testimony largely in favor of adopting Resolution 208 as consistent with existing AMA policies on reducing health care disparities in minority populations, educating physicians, residents, and medical students about cultural sensitivities and cultural competency in treating minority populations, and reducing domestic violence against women. Your Reference Committee also heard testimony commending the authors of this resolution for addressing this serious and complicated issue. Your Reference Committee heard testimony that the Family Wellness Warriors Initiative has developed a three-year model for Alaska Natives to equip individuals and communities with the education, skills, and tools to reverse domestic violence and child maltreatment.

Your Reference Committee heard testimony regarding the first clause of the first resolve that the jurisdictional and logistical issues referenced in the resolution are complex and complicated and present political challenges at many levels. Testimony was also presented that it might be more prudent to amend the first resolve to remove the directive that calls on our AMA to lobby the Senate Committee on Indian Affairs and appropriate authorities to resolve the logistical and jurisdictional issues that place Native women at increased risk for sexual violence. Your Reference Committee also heard testimony in support of the educational initiatives in the second resolved, but cautioning

against language that could be interpreted as mandating curriculum changes. Your Reference Committee agrees, and therefore recommends that Resolution 208 be adopted as amended.

(7) RESOLUTION 210 - SUPPORT FOR THE VETERANS TO PARAMEDICS TRANSITION ACT OF 2015

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association support legislation to allow enable veterans who desire to serve as paramedics to obtain training to satisfy emergency medical services personnel certification requirements, taking into account previous medical coursework and training received when such veterans were members of the armed forces served as medics or corpsmen to receive expedited training to be eligible for paramedic certification.

RECOMMENDATION B:

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

HOD ACTION: Resolution 210 adopted as amended.

Resolution 210 asks that our American Medical Association support legislation to allow veterans who served as medics or corpsmen to receive expedited training to be eligible for paramedic certification.

Your Reference Committee heard strong support for the spirit of Resolution 210. Your Reference Committee echoes the unanimous testimony lauding members of our armed forces and the need to recognize the excellent emergency training received by many men and women who serve our country. The issues raised in Resolution 210 are relevant and timely. Your Reference Committee appreciates that the groups concerned about the original resolution's language—including those representing our armed forces—came together and found a compromise solution to the concerns raised. Your Reference Committee therefore recommends that Resolution 210 be adopted as amended.

(8) RESOLUTION 211 - PROTECT HEALTHCARE.GOV CONSUMERS' PERSONAL DATA

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association support legislation that prohibits the inappropriate sharing of personal health and other personal information obtained from state and federally facilitated health insurance marketplaces such as HealthCare.gov.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 211 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 211 be changed to read as follows:

PROTECTING CONSUMERS' PERSONAL DATA

HOD ACTION: Resolution 211 adopted as amended with a change in title.

Resolution 211 asks that our American Medical Association support legislation that prohibits the inappropriate sharing of personal health information obtained from state and federally facilitated health insurance marketplaces such as HealthCare.gov.

Your Reference Committee heard supportive testimony on Resolution 211. However, testimony noted that the importance of protecting individuals' privacy extends beyond the HealthCare.gov portal, and an amendment was offered to make the resolution broader in its scope and application. Accordingly, your Reference Committee recommends that Resolution 211 be amended to reflect our AMA's commitment to protecting personal data more broadly.

(9) RESOLUTION 212 - EHR INTEROPERABILITY
RESOLUTION 219 - EHR INTEROPERABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends adoption of Substitute Resolution 212 in lieu of Resolution 219.

RESOLVED, That our American Medical Association continue efforts to support electronic health record (EHR) interoperability, AMA enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; and be it further

RESOLVED, That our AMA support and encourage Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; and be it further

RESOLVED, That our AMA develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; and be it further

RESOLVED, That our AMA continue efforts to promote interoperability of EHRs and clinical registries; and be it further

RESOLVED, That our AMA seek ways to facilitate physician choice in selecting or migrating between EHR systems that is independent from hospital or health system mandates; and be it further

RESOLVED, That our AMA seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and that our AMA seek suspension of all Meaningful Use penalties by insurers, both public and private.

HOD ACTION: Substitute Resolution 212 adopted as amended in lieu of Resolution 219.

Resolution 212 asks that our American Medical Association study and distribute a report by the 2016 Annual Meeting documenting the progress and status of those established Policies and Directives to Take Action intended to promote development of effective electronic health records (including, but not limited to, those referenced in D-478.995, D-478.996, H-480.971, D-478.991, D-478.994, H-450.933, H-406.987, H-480.971), especially related to issues of common interfaces and interoperability, to be updated yearly until the results are satisfactory ; submit a

report to the Department of Health and Human Services, the Office of the National Coordinator and CMS (and made available to members of Congress and the media) no later than June, 2016, concerning shortcomings in electronic health record (EHR) interoperability and related issues, urging that action be taken no later than the timeline outlined in H.R.2 - 114th Congress (2015-2016) Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, with special emphasis on requiring vendors to provide systems that comply with interoperability standards as a basic requirement for certification without significant additional cost to end users ; and insist that hospitals and health systems be prevented from requiring, as a condition for privileges, specific brands of EMRs for affiliated but independent private physicians ; and that any clinician who has previously attested for Meaningful Use not be penalized in any way if the EMR technology previously used is decertified subsequently. Resolution 219 asks that our American Medical Association continue efforts to support electronic health record (EHR) interoperability ; support and encourage Congress to enact legislation as quickly as possible to (1) eliminate unjustified information blocking; and (2) ensure that healthcare providers and patients should not have to bear costs of EHR interoperability issues ; and continue efforts to prevent expansion of Meaningful Use and other programs like the Comprehensive Care for Joint Replacement Payment Model until EHR interoperability is accomplished.

Your Reference Committee heard supportive testimony on resolutions 212 and 219, which outline the significant barriers to interoperability. Many emphasized that the Meaningful Use program is a significant cost and disruption to physician practices and that physicians should not be penalized for technology that is not capable of seamlessly exchanging patient data and improving physician workflow. Testimony highlighted that interoperability and information exchange is being blocked by a number of factors, including high costs, the lack of advanced technology, and health system policies that prevent physician choice. Those testifying noted that these concerns were also addressed at the Annual 2015 meeting and that several resolutions related to interoperability were referred for additional study. Our AMA will be reporting back on these resolutions at the Annual Meeting in 2016. Testimony from the Council on Legislation noted that our AMA has already presented comprehensive comments outlining a roadmap to achieve interoperability to relevant agency officials and is working with Congress and stakeholders to address current data exchange barriers. Your Reference Committee also heard testimony that our AMA should advocate for a moratorium on penalties associated with the Meaningful Use program until EHR interoperability is accomplished. Based on ongoing AMA advocacy and the recent release of new Meaningful Use regulations, the Council on Legislation offered a substitute resolution that would combine the goals of these resolutions and align them with ongoing advocacy efforts. Your Reference Committee agrees with the testimony heard and recognizes the numerous efforts by our AMA to address the lack of interoperability, including the future report that will be received by the House of Delegates at the 2016 Annual meeting. Therefore, your Reference Committee recommends adoption of substitute Resolution 212 in lieu of Resolutions 212 and 219.

(10) RESOLUTION 213 - OPIOID ABUSE-DETERRENT PRESCRIPTION DRUGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 213 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the Food and Drug Administration's ongoing efforts to evaluate the efficacy, safety, and labeling of and label abuse-deterrent technology.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 213 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA oppose barriers to appropriate access to and coverage of prescription drugs the regulatory or legislative imposition of administrative deterrents that decrease access to and coverage of prescription drugs with abuse-deterrent properties.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 213 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 213 be changed to read as follows:

ABUSE-DETERRENT PRESCRIPTION DRUGS

HOD ACTION: Resolution 213 adopted as amended with a change in title.

Resolution 213 asks that our American Medical Association support the Food and Drug Administration's ongoing efforts to evaluate and label abuse-deterrent technology ; and oppose the regulatory or legislative imposition of administrative deterrents that decrease access to and coverage of prescription drugs with abuse-deterrent properties.

Your Reference Committee heard consistent support for the intent of Resolution 213. Your Reference Committee agrees with testimony concerned about patient access to prescription drugs with abuse-deterrent properties, as well as concern related to coverage and the inclusion of specific conditions and populations. Your Reference Committee took these concerns very seriously and therefore recommends that Resolution 213 be adopted as amended.

(11) RESOLUTION 221 - INDEMNITY FOR BREACHES IN ELECTRONIC HEALTH RECORD CYBERSECURITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 221 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study advocate on the timely issue of providing for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises and report back at the 2016 Annual Meeting.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 221 be adopted as amended.

HOD ACTION: Resolution 221 adopted as amended.

Resolution 221 asks that our American Medical Association study the timely issue of providing indemnity for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises and report back at the 2016 Annual Meeting.

Your Reference Committee heard testimony in support of the intent of Resolution 221 that highlighted the growing concern with security and privacy breaches as more patient information is being stored electronically. Testimony noted that our AMA has considered this topic and existing AMA policy clarifies that HIPAA protections and requirements equally apply to information stored in electronic health records. Indemnity would therefore depend on the contractual and legal obligations created under HIPAA. Rather than continue to study this topic, testimony noted that our AMA should seek to work with interested stakeholders in the medical professional liability community and engage with relevant policymakers to provide greater clarity and indemnity or other liability protections for physicians in the case of a cyberattack or other technology breach. Your Reference Committee also heard testimony speaking to the need to educate physicians who may face liability as a result of a security breach of electronic health

records. Your Reference Committee agrees with the testimony heard and, noting that our AMA will hear a status report on these advocacy activities at the 2016 Interim Meeting as a result of the amended resolution, believes that Resolution 221 should be adopted as amended.

(12) RESOLUTION 224 - OPPOSE FUNDING RESTRICTIONS ON HEALTH CENTERS RECEIVING TITLE X AND/OR MEDICAID FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Substitute Resolution 224 be adopted.

RESOLVED, That our American Medical Association support access to preventive and reproductive health services for all patients and oppose legislative ~~proposals and regulatory actions~~ that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 224 be changed to read as follows:

SUPPORT FOR ACCESS TO PREVENTIVE AND REPRODUCTIVE HEALTH SERVICES

HOD ACTION: Substitute Resolution 224 adopted as amended with change in title.

Resolution 224 asks that our American Medical Association support access to preventative and reproductive health services for all patients and oppose legislation and restrictions that diminish funding and/or access to such services ; and that our AMA oppose restrictions for funding of all providers and clinics who provide preventive and reproductive health services, when those providers and clinics otherwise meet the usual standards for eligibility .

Your Reference Committee heard a significant amount of testimony on Resolution 224. In particular, your Reference Committee heard an overwhelming amount of testimony in support of access to health care. Testimony in support of Resolution 224 also noted that the resolution is consistent with longstanding AMA policy supporting women's health and access to preventive and reproductive health care services. Similarly, your Reference Committee heard testimony emphasizing considerable preventive health care services funded by Title X, including in Planned Parenthood clinics, such as testing and treatment for sexually transmitted disease; contraception initiation, maintenance and counseling; women's health services; and cancer screening in the form of Pap smears, breast exams, and colorectal cancer screening. Your Reference Committee also heard that our AMA should be guided by an ideology focused on providing the best care for patients, particularly those who have limited access to health care due to socioeconomic factors.

However, your Reference Committee heard several points of testimony in opposition to Resolution 224, and testimony expressing concern that the second Resolve of Resolution 224 might unintentionally be overly broad. Your Reference Committee believes that language from AMA policy H-5.998, Public Funding of Abortion Services, captures the intent and spirit of Resolution 224 while addressing the concerns raised about the second Resolve. For these reasons, your Reference Committee recommends that substitute Resolution 224 be adopted with a change in title.

(13) RESOLUTION 225 - DRAFT CLINICAL QUALITY MEASURES NON-RECOMMENDED PSA-BASED SCREENING

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association continue to advocate for inclusion of relevant specialty societies and their members in guideline and performance measure development, including in technical expert panels charged with developing performance measures against the Centers for Medicare & Medicaid Services' utilization of measures and screenings recommendations derived without input from medical expertise that is relevant to the disease state or health condition.

RECOMMENDATION B:

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

HOD ACTION: Resolution 225 adopted as amended.

Resolution 225 asks that our American Medical Association advocate against the Centers for Medicare & Medicaid Services' utilization of measures and screenings recommendations derived without input from medical expertise that is relevant to the disease state or health condition ; and that our AMA work with the federal government, specialty societies, and other relevant stakeholders to develop guidelines and clinical quality measures for the prevention or early detection of disease, such as prostate cancer, based on rigorous review of the evidence which includes expertise from any medical specialty for which the recommendation may be relevant to ultimately inform shared decision making.

Your Reference Committee heard mixed testimony on Resolution 225. Speakers recognized the importance of robust clinician input during guideline and measure development and the challenges faced by patients and clinicians when there are competing or conflicting guidelines. Testimony also suggested that existing AMA policy covers these important goals. Your Reference Committee also heard that in advocacy on MACRA implementation, your AMA is already calling for CMS to rely on specialties as it develops quality measures. It was suggested that the first Resolve of Resolution 225 be amended to reflect this ongoing advocacy and clarify what that advocacy is for (reliance on medical specialty expertise when developing quality measures) rather than what the advocacy is against. Your Reference Committee agrees and therefore recommends that Resolution 225 be adopted as amended.

(14) RESOLUTION 214 - AMA SUPPORT FOR STATE MEDICAL SOCIETIES' EFFORTS TO IMPLEMENT MICRA-TYPE LEGISLATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-435.969, H-435.983, H-435.978, and H-435.975 be reaffirmed in lieu of the first Resolve of Resolution 214.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 214 be referred.

HOD ACTION: Policies H-435.969, H-435.983, H-435.978 and H-435.975 reaffirmed in lieu of the first Resolve of Resolution 214. Second Resolve of Resolution 214 referred.

Resolution 214 asks that our American Medical Association continue to support state medical Societies' efforts to implement MICRA-type legislation , and engage its leadership and staff, those of the national medical specialty societies, and other stakeholder organizations to provide resources and technical assistance to efforts throughout the federation to defeat no fault medical liability legislation.

Your Reference Committee heard that the first Resolve of Resolution 214 is well covered by existing AMA policies H-435.969, H-435.983, H-435.975 and H-435.978, as well as past and ongoing AMA advocacy activities on medical liability reform.

Your Reference Committee heard mixed testimony on the second Resolve of Resolution 214. Testimony was presented that administrative compensation systems may be more dependable and less stressful for all parties, and that at least one association has called for pilot testing of models including administrative compensation systems. Your Reference Committee also heard testimony that administrative compensation systems may increase reporting to the National Practitioner Databank and increase overall health care costs while doing nothing to improve the quality of care. Your Reference Committee also heard from one state with experience advocating against administrative compensation system legislative proposals that the methodology behind such systems are risky and poorly thought out. Your AMA Council on Legislation indicated an interest in studying this proposal further, noting that your AMA Advocacy Resource Center is already working with state medical associations and other interested stakeholders to collect data, study administrative compensation systems and develop advocacy resources on this proposal. The Council testified that it would welcome the opportunity to study this issue further. Your Reference Committee agrees that this is an important issue that warrants further study, and for that reason, recommends referral of the second Resolve of Resolution 214. Your Reference Committee therefore recommends that AMA policies H-435.967, H-435.968, H-435.969, H-435.983, H-435.975, and H-435.978 be reaffirmed in lieu of the first Resolve of Resolution 214, and that the second Resolve of Resolution 214 be referred.

H-435.969 Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability

Our AMA: (1) reaffirms its support for investigating promising Alternative Dispute Resolution (ADR) mechanisms, in the context of demonstration projects designed to evaluate whether they resolve medical liability claims fairly and in a more timely and cost-effective manner. (2) The AMA strongly recommends that if cost containment goals are to be achieved, ADR proposals designed to provide greater access to legal process must incorporate effective mechanisms to: (a) identify non-meritorious claims and dispose of them; (b) decrease the proportion of cases being litigated; (c) increase the portion of any settlement payment received by the patient; and (d) identify appropriate guidelines for the payment of damages; and (3) continues to monitor and disseminate information to state and component medical societies about state and federal initiatives that address the issue of protections from liability risks for physicians who provide volunteer activities and care of the indigent, as well as the effectiveness of those initiatives. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

H-435.983 Impact of Product Liability on the Development of New Medical Technologies

The AMA (1) urges the continuation of efforts at the state and federal level to reform product liability laws, (2) supports creative solutions to prevent product liability suits from slowing the development and utilization of medical technologies in this country. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform; and (3) continues to support efforts to alleviate the growing health crisis caused by decreasing availability or provision of biomaterials to manufacturers of medical devices and implants and to support legislative efforts to provide legal protection to biomaterial suppliers to ensure that all Americans have access to medical devices.

H-435.975 Bush Administration Professional Liability Proposal

Our AMA commends the Bush Administration for its legislative efforts designated to achieve medical liability reform and supports the elements of legislative proposals introduced in the 102nd Congress which are consistent with Association policy, including (1) limitations of \$250,000 or lower on recovery of non-economic damages; (2) the mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing, sliding scale regulation of attorney contingency fees; (4) periodic payment of future awards of damages; and (5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

H-435.978 Federal Medical Liability Reform

Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of \$250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral

sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

(15) **RESOLUTION 222 - MODEL STATE LEGISLATION PROMOTING THE USE OF ELECTRONIC TOOLS TO MITIGATE RISK WITH PRESCRIPTION OPIOID PRESCRIBING**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 222 be referred.

HOD ACTION: Resolution 222 referred.

Resolution 222 asks that our American Medical Association develop model state legislation that improves workflow for using state based prescription monitoring programs by enhancing information available including automated alert notification of doctor shopping, real time EHR-PMP integration, and e-prescribing of schedule II and III drugs which should be essential parts of a state based risk mitigation strategy with identification and correction of any workflow or technological barriers a high priority ; and that stage 3 of the federal government's meaningful use program should be delayed until the following are accomplished: a) real time integration of EHRs and state based PMPs, and b) electronic prescribing of schedule II and III drugs are available for meaningful use certified EHRs in the United States.

Testimony supported referral of Resolution 222. Your Reference Committee strongly supports the intent of this resolution. Moreover, your Reference Committee lauds our AMA and its Federation partners in forming our AMA Task Force to Reduce Opioid Abuse and working tirelessly to end the nation's opioid epidemic. The issues raised in Resolution 222 are multifaceted and complex. Your Reference Committee also commends our AMA Council on Legislation for working to develop several pieces of model state legislation to help states ensure appropriate patient treatment and prevention of death from overdose. Due to the complexity of the issues raised in the resolution and because these issues deserve individual attention, your Reference Committee agrees that Resolution 222 should be referred.

(16) **RESOLUTION 223 - INFERTILITY BENEFITS FOR WOUNDED WARRIORS**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 223 be referred.

HOD ACTION: Resolution 223 referred.

Resolution 223 asks that our American Medical Association support lifting the Congressional ban on the Department of Veterans' Affairs from covering in vitro fertilization (IVF) costs ; and that our AMA work with the American Society for Reproductive Medicine and other interested organizations to encourage lifting the Congressional ban on the Department of Veterans' Affairs from covering in vitro fertilization (IVF) costs.

Your Reference Committee heard supportive testimony on providing reproductive services, such as IVF, to veterans and their families. However, testimony also revealed that there are significant complexities with this issue that require further study and clarification. For example, testimony emphasized that it may be prudent to specify that Department of Veterans' Affairs (VA) coverage for IVF would only apply to beneficiaries whose infertility stems from a service-connected injury or disability. Testimony also noted that our AMA's goal should be to seek parity between private and VA coverage, meaning that additional data about IVF coverage among private insurance plans would be helpful to consider. Moreover, questions remained about different VA classes of beneficiaries, and which categories of individuals would be entitled to specific medical services. In light of the cost associated with IVF procedures, your Reference Committee believes that additional research would aid in reaching a well-informed and sustainable AMA policy position. Based on the aforementioned testimony, your Reference Committee urges referral of Resolution 223.

(17) RESOLUTION 205 - INCLUSION OF HEALTH INSURERS' FINANCIAL SUPPORT TO GRADUATE MEDICAL EDUCATION IN THE MEDICAL LOSS RATIO

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 205 not be adopted.

HOD ACTION: Resolution 205 not adopted.

Resolution 205 asks that our American Medical Association advocate that health insurers who provide financial support for expansion and or continuation of existing graduate medical education programs be allowed to include such sums as direct medical expenditures as part of the calculation of the Medical Loss Ratio ; and advocate for relevant federal and state regulatory changes to allow inclusion of the health insurers' financial support for graduate medical education in the Medical Loss Ratio of their health plans.

Your Reference Committee heard supportive testimony with respect to the spirit of Resolution 205, which noted that our AMA has considerable and long-standing policy supporting all-payer funding for graduate medical education (GME). Our AMA also supports requiring health plans to disclose in a clear and concise standard format accurate information on medical loss ratios, including separately reporting administrative costs vs. medical care costs. However, your Reference Committee also heard that the issue of what is or should be included as part of medical care expenses as opposed to administrative costs in the medical loss ratio is complicated, and the solution offered could have the unintended consequence of diverting funds that would otherwise be dedicated to medical care expenses.

Your Reference Committee also heard testimony on the need to study alternative sources of GME funding. Our AMA Council on Medical Education brought your Reference Committee's attention to Council on Medical Education Report 1-I-15, Sources of Funding for Graduate Medical Education, which is currently under consideration and: 1) briefly summarizes current funding for GME; 2) presents examples of private and alternative funding for GME, both current and past; 3) describes proposals developed for new models of funding; and 4) presents an example of a program expansion that can serve as the groundwork for the development of model guidelines for program expansion. Your Reference Committee recognizes that the Council on Medical Education has developed several reports on GME funding in recent years, many which are publicly available on the Council's website as a resource for those interested in pursuing alternative sources of GME funding. Your Reference Committee believes that these reports sufficiently address the objectives of the Resolution. For these reasons, your Reference Committee recommends that Resolution 205 not be adopted.

(18) RESOLUTION 203 - QUALITY ASSURANCE AND MEANINGFUL USE REQUIREMENTS
RESOLUTION 216 - SIMPLIFICATION AND ALIGNMENT OF PORTAL SYSTEMS BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-450.936, D-450.964, D-450.967, D-478.982, H-450.966, and H-450.947 be reaffirmed in lieu of Resolutions 203 and 216.

HOD ACTION: Policies H-450.936, D-450.964, D-450.967, D-478.982, H-450.966, and H-450.947 reaffirmed in lieu of Resolutions 203 and 216.

Resolution 203 asks that our American Medical Association seek revisions to quality assurance standards and meaningful use requirements to make them more streamlined, usable and less burdensome , advocate in the Centers for Medicare & Medicaid's (CMS) continual design and development of the Enterprise Identity Management (EIDM) system for a one-portal system with one username and one password to ensure that the identity verification, data reporting, and retrieval processes for all future quality programs are aligned , and work with CMS as a key stakeholder in the design and implementation of feedback reports that are timely, user-friendly, and relevant to physician specialties and practice settings. . Resolution 216 asks that our AMA advocate in the CMS continual design and development of the EIDM system for a one-portal system with one username and one password to ensure that the identity verification, data reporting, and retrieval processes for all future quality programs are aligned , and work with CMS as a key stakeholder in the design and implementation of feedback reports that are timely, user-friendly, and relevant to physician specialties and practice settings.

Your Reference Committee heard testimony supportive of Resolutions 203 and 216. It is clear from those testifying that there is a high level of frustration among physicians with the meaningful use program. A representative from the Board of Trustees noted that our AMA has several existing policies addressing the concerns of these two resolutions, and has been engaged in an aggressive advocacy campaign to that includes all levels of the Administration, Congress, and key stakeholders to improve the Meaningful Use program. Also, our AMA created both the Physicians Consortium for Performance Improvement (PCPI) Foundation as well as the National Quality Registry Network (NQRN) to assist in the development of quality measures and registries for physician quality reporting. Work by these entities is actively advancing the idea of measure alignment, unified definitions, and common core data sets for quality reporting. Your Reference Committee also notes that our AMA is actively working to allow reporting to registries and the Physician Quality Reporting System (PQRS) to be deemed as satisfying the Meaningful Use quality reporting requirements. Importantly, all of the existing quality programs will be combined under the new Merit-Based Incentive Payment System (MIPS) that was recently enacted by Congress, providing an opportunity to streamline the reporting requirements. Your Reference Committee strongly supports the goals of Resolutions 203 and 216, which are consistent with existing AMA policy. Therefore, in recognition of ongoing advocacy activities guided by existing AMA policy, your Reference Committee recommends reaffirmation of the following policies in lieu of adoption of Resolutions 203 and 216 to avoid disrupting ongoing advocacy efforts.

H-450.936 Physician Quality Reporting Initiative Payment

Our AMA will continue to advocate for improvements in the Physician Quality Reporting Initiative (PQRI) including early education and outreach to physicians by the Centers for Medicare and Medicaid Services (CMS), the provision of confidential interim and final feedback reports from CMS to physicians on potential problems in their PQRI reporting, easier access to feedback reports, development of meaningful dispute resolution processes, and the provision to our AMA of the 2007 PQRI data set file.

D-450.964 Medicare Quality and Resource Use Reports

Our AMA will continue to work with the Centers for Medicare & Medicaid Services to improve the design, content, and performance indicators included in the Quality and Resource Use Reports (QRURs) for physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating Value-Based Payment Modifiers (VBM).

D-450.967 The PQRI Reporting Standard Should be Amended

Our AMA will petition the Centers for Medicaid and Medicare Services to streamline and make less arduous the reporting standard of the Physicians' Quality Reporting Initiative and ask Congress to delay implementation of the mandatory nature of the program until the system has been refined to be more efficient and physician friendly.

D-478.982 Redefine "Meaningful Use" of Electronic Health Records

Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation. 2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.

H-450.966 Quality Management

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

H-450.947 Pay-for-Performance Principles and Guidelines

1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.¹ All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.² Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.³ All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.⁴ Performance measures should be scored against both absolute values and relative improvement in those values.⁵ Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.⁶ Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.⁷ Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care. 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.² Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).¹ Programs should provide physicians with tools to facilitate participation.² Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.¹ Programs should use accurate administrative data and data abstracted from medical records. ² Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.³ Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.¹ Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.² Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance

(19) RESOLUTION 218 - NATIONAL DISASTER HEALTHCARE VOLUNTEER INITIATIVE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-130.942, D-130.972, and H-130.941 be reaffirmed in lieu of Resolution 218.

HOD ACTION: Policies H-130.942, D-130.972, and H-130.941 reaffirmed in lieu of Resolution 218.

Resolution 218 asks that our American Medical Association advocate for passage of the Emergency Management Assistance Compact, which includes professional liability relief for responders to disasters.

Your Reference Committee heard testimony supportive of the goal of professional liability protection for physicians who provide medical care in response to disasters. However, the Emergency Management Assistance Compact (EMAC) has already been adopted by all fifty states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. Moreover, Congress ratified EMAC in 1996 in Public Law 104-321.

In addition, testimony noted that the laudable goals of Resolution 218 are already addressed by existing AMA policies and ongoing advocacy activities. For example, our AMA has developed state model legislation on civil immunity for emergency volunteer physicians, and is supporting the Good Samaritan Health Professionals Act (H.R. 865), which would protect health care professionals who volunteer during a federally-declared disaster from liability exposure. As such, your Reference Committee urges that the following AMA policies be reaffirmed in lieu of Resolution 218.

H-130.942 Development of a Federal Public Health Disaster Intervention Team

1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).

2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups. 3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.

D-130.972 All Hazards Disaster Preparedness and Response

Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster.

H-130.941 Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters

Our AMA: (1) encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and (2) (a) supports the National Conference of Commissioners on Uniform State Laws (NCCUSL) Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with the liability language of Alternative A; and (b) continues to advocate for civil liability protections for qualified physicians that provide care in a disaster who are not covered under the UEVHPA, but are covered in AMA model legislation titled "To Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster."

REPORT OF REFERENCE COMMITTEE F

(1) BOARD OF TRUSTEES REPORT 2 - DONATING REIMBURSEMENTS TO THE AMERICAN MEDICAL ASSOCIATION

RECOMMENDATION:

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

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

Board of Trustees Report 2 comes in response to Resolution 602-A-15, which called upon our AMA to explore using non-employee travel reimbursement worksheets to allow members of the Board of Trustees, councils, and sections the option of donating a tax-deductible portion, or the total amount, of their travel reimbursement to the AMA Foundation Minority Scholars Fund or other AMA Foundation programs benefitting medical students.

Because of concerns expressed in Board of Trustees Report 2, the impact on reimbursement processing, and the readily available alternate forms of donation (i.e., telephone, mail, online, or in person) the Board of Trustees recommends that the following be adopted in lieu of Resolution 602-A-15 and the remainder of the report be filed:

That our American Medical Association add verbiage to its non-staff expense form directing individuals to the AMA Foundation's website should they wish to make a contribution.

Your Reference Committee heard only supportive testimony and commends the Board of Trustees for a brief but comprehensive report highlighting the historical relationship between our AMA and the AMA Foundation. Your Reference Committee believes the report identifies a workable mechanism to promote donations to all the AMA Foundation's worthy and important programs.

(2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT
1 - BEST PRACTICES AND SUCCESSFUL EFFORTS TO INCREASE DIVERSITY, BY AGE, OF AMA DELEGATES AND ALTERNATE DELEGATES

RECOMMENDATION:

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

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

Council on Long Range Planning and Development Report 1 presents recommendations for action aimed at enhancing diversity, particularly by age, among the House of Delegates. The Council has identified leadership training programs, sections, term limits, and slotted seats as practices with the potential to increase age diversity among delegations.

To this end, the Council on Long Range Planning and Development recommends that the following statements be adopted and that the remainder of this report be filed:

That our American Medical Association Reaffirm Policy G-600.035, which calls for an annual analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year; and future reports to include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations. (Reaffirm HOD Policy)

That our American Medical Association convene a group of stakeholders at a forum in conjunction with the 2016 Annual Meeting to identify viable solutions with which to promote diversity, particularly by age, of state and specialty society delegations, with a summary of the findings to be included in the next CLRPD report on the demographic characteristics of the House of Delegates.

At the 2015 Annual Meeting, testimony indicated a clear desire for the Council on Long Range Planning and Development to recommend viable solutions for positively affecting the demographics of our AMA House of Delegates.

Testimony at this meeting continued to favor convening an open forum at A-16 to identify and discuss best practices to address diversity in its broadest sense, not limited only to age diversity. Testimony also included specific concerns and potential solutions, which will be welcomed at the A-16 open forum.

Your Reference Committee appreciates that the Council accepted this expanded charge and strongly supports the convening of stakeholders at the 2016 open forum. Your Reference Committee believes that a subsequent report from the Council outlining best practices and a potential future action plan will address the concerns presented.

(3) BOARD OF TRUSTEES REPORT 12 - AFFILIATE MEMBERSHIP

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be amended by addition to read as follows:

1. That the American Medical Association eliminate the pathway to future membership under the affiliate membership category while preserving the status held by individuals who have already met the requirements and have been approved for affiliate membership, category or status and that the Council on Constitution and Bylaws draft appropriate amendments to the Bylaws to effect such.

RECOMMENDATION B:

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

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

Board of Trustees Report 12 comes in response to Policy G-635.065, which stemmed from the Council on Constitution and Bylaws Report 4-A-14, "Moratorium on AMA Affiliate Members." Policy G-635.065 asked that the Board of Trustees study the issue of affiliate membership and address the rationale for affiliate membership. The House of Delegates (HOD) instituted a moratorium on considering any other affiliate members until the issue was studied and a report back to the HOD could be presented.

Board of Trustees Report 12 highlights that AMA Affiliate members do not pay dues, do not receive membership benefits other than being allowed to attend meetings, are not included in our AMA's membership count, and do not receive communications from our AMA. Furthermore, overall demand for an AMA Affiliate membership is low and creates the potential for reputational risk. For these reasons, the Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association eliminate the affiliate membership category while preserving the status held by individuals who have already met the requirements and have been approved for affiliate

membership category or status, and that the Council on Constitution and Bylaws draft appropriate amendments to the Bylaws to effect such.

2. That our AMA rescind Policy G-635.065, which has been accomplished by this report.

Your Reference Committee believes that Board of Trustees Report 12 delivers persuasive and cogent arguments for eliminating the affiliate membership category. In addition, the amended language presented during testimony allows retention of “grandfathered” affiliate members.

(4) **RESOLUTION 602 - REDUCING DISCRIMINATION IN THE PRACTICE OF MEDICINE AND HEALTH CARE EDUCATION**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 602 be referred.

HOD ACTION: Resolution 602 referred for decision.

Resolution 602 calls upon our AMA to collaborate with the American Public Health Association (APHA) and other partners in a National Campaign Against Racism to include:

- identification of and education on implementation of successful anti-racism interventions in medical settings;
- development of policies and practices that will reduce the negative effects of racism, sexism, religious and class prejudice within society as a whole, and specifically within the practice of medicine; and
- support for the preparation, training, and education of professionals in the medical, nursing, pharmaceutical, and allied health specialties who wish to enter the health care field.

Testimony in response to Resolution 602 uniformly supported the intent of the Resolution. Testimony also reflected that our AMA has longstanding policy calling for the elimination of racial and ethnic health disparities. This issue is among our AMA’s highest priorities and has resulted in a number of successful AMA initiatives and new partnerships (e.g., Commission to End Health Care Disparities). Your Reference Committee also highlights testimony that emphasized the goal should strive to not merely reduce, as stated in the resolution, but to eliminate racial disparities.

Your Reference Committee supports referral of Resolution 602 to open a dialogue with the American Public Health Association (APHA) about their new National Campaign Against Racism. Additionally, your Reference Committee favors allowing our AMA Board of Trustees an opportunity to bring back a fully vetted report as to how the APHA campaign aligns with current AMA Policy and initiatives in this area, as well as the fiscal impact of this endeavor.

REPORT OF REFERENCE COMMITTEE J

(1) COUNCIL ON MEDICAL SERVICE REPORT 1 - UPDATE ON PAYMENT MECHANISMS FOR PHYSICIAN-LED TEAM-BASED HEALTH CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

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

Council on Medical Service Report 1 recommends that our AMA reaffirm Policies H-160.912 and H-160.908; encourage public and private health insurers to develop and offer a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care; encourage the Centers for Medicare & Medicaid Services (CMS) to ensure that Medicare Alternative Payment Models (APMs) do not require physicians to assume responsibility for costs they cannot control; continue to actively advocate to CMS that physicians in all specialties and modes of practice must have at least one Medicare APM in which they can feasibly participate; advocate to CMS that any review process of alternative payment models proposed by stakeholders be completed in a timely manner, include an administratively simple appeals process and access to an ombudsman; and rescind Policy D-160.933[2].

Positive testimony was heard on Council on Medical Service Report 1. An amendment was submitted to include “and assure fair payment for physicians” at the end of Recommendation 2; however, that would entail modifying existing policy. Your Reference Committee notes that AMA Policy H-160.908 supports fair payment for physician-led team-based care.

Testimony inquired about the definition of team-based care as well as the roles of team members. AMA Policy H-160.912 defines “team-based health care” as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care. Furthermore, AMA Policy H-160.906 outlines the roles of team members in detail.

The Council on Medical Service testified that a report on payment models is forthcoming at A-16. Your Reference Committee recommends that Council on Medical Service Report 1 be adopted.

(2) COUNCIL ON MEDICAL SERVICE REPORT 3 - EMERGENCY PRESCRIPTION DRUG REFILLS

RECOMMENDATION:

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

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

Council on Medical Service Report 3 recommends principles to guide the dispensing of emergency refills of prescription drugs.

There was generally supportive testimony on this report. A speaker suggested that the reference to the pharmacist's professional judgment be removed in Principle A of the recommendation of Council on Medical Service Report 3. However, your Reference Committee believes that tying the dispensing of an emergency refill to a pharmacist's professional judgment not only is inextricably linked to the pharmacist liability for emergency refills, but stipulates

that a non-pharmacist member of the pharmacy staff cannot make the determination to authorize an emergency refill. Related, your Reference Committee believes that Principle J is essential, as physicians should not be subject to liability for any damages resulting from an emergency refill of a prescription drug by a pharmacist. There was also a concern raised with Principle E, and an amendment was proffered to limit the supply of a prescription drug to be dispensed in the case of an emergency order or proclamation of a state of emergency issued by a state's governor to a 72-hour supply. However, a member of the Council on Medical Service clarified that the principle allowed for a supply up to 30 days, so that amount is a ceiling, not a floor. Also, the Council member stressed that all emergencies are different. Your Reference Committee agrees that Principle E is flexible to be applicable to a wide range of emergencies, and notes that the principle also defers to any other amount that may be provided for under existing state law. Your Reference Committee believes the principles recommended in this report will be helpful in guiding future legislation, regulations and protocols addressing emergency refills. Accordingly, your Reference Committee recommends that the recommendation of Council on Medical Service Report 3 be adopted.

(3) COUNCIL ON MEDICAL SERVICE REPORT 8 - HEALTH INSURANCE AFFORDABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

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

Council on Medical Service Report 8 contains recommendations to improve access to and awareness of affordable health insurance coverage for individuals, employees and their families.

There was generally supportive testimony on this report. A speaker raised concern with the first, second and fourth recommendations of the report, and stressed that the recommendations of the report would worsen the nation's deficit. However, the chair of the Council on Medical Service stressed that the fourth recommendation of the report pays for all of the recommendations of the report; therefore, the recommendations of the report are budget neutral. In addition, speakers were in support of the Council continuing to monitor the issue of high-deductible health plans, and report back to the House of Delegates with worthy developments and new policy recommendations. A member of the Council on Medical Service stated that it is the Council's intention to continue to follow the issue, and will report back as additional data and recommendations become clear. Your Reference Committee believes that the recommendations of this report will help provide millions of workers and their families with access to coverage offered on health insurance exchanges, which is oftentimes more affordable than the coverage provided through their employer. In addition, the report recommendations will help to improve the overall affordability of bronze plans, which have high deductibles and cost-sharing, for individuals with the lowest incomes. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 8 be adopted.

(4) RESOLUTION 801 - HEALTH CARE WHILE INCARCERATED

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 801 be adopted.

RESOLVED, That our American Medical Association study mental health and health care for incarcerated juvenile and adult individuals and identify the best mental health and health care models for local, state and federal facilities.

HOD ACTION: Resolution 801 adopted as amended.

Resolution 801 asks that our AMA study health care for incarcerated individuals and identify the best health care models for local, state and federal facilities.

Supportive testimony was heard on Resolution 801 emphasizing the need to eliminate the multiple barriers to accessing health care that incarcerated individuals experience. Several amendments were submitted that your Reference Committee concurs with; however, many other important verbal suggestions were made regarding what the study should address. As such, your Reference Committee suggests that the proposed study review the provision of mental health care services; access to and continuity of health care; the health care needs of both juvenile and adult populations; training of correctional facility staff on mental health care and providing prenatal care, delivery support and postpartum care; and the use and interoperability of correctional facility electronic health records. Addressing individual health care needs throughout the full continuum of incarceration should be a focus of the requested study.

(5) **RESOLUTION 816 - PROTECT MEDICARE BENEFICIARY ACCESS TO COMPLEX REHABILITATION WHEELCHAIRS**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 816 be adopted.

HOD ACTION: Resolution 816 adopted.

Resolution 816 asks that our AMA strongly encourage the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices; and in the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, asks that our AMA encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

There was unanimous supportive testimony on this resolution. Your Reference Committee appreciates expert testimony from professionals in the field highlighting that customized, sophisticated wheelchairs and accessories keep these patients functioning at their highest capacity. Additionally, your Reference Committee appreciates that this resolution aims to preserve patient access to care and respect the judgment of physicians. Accordingly, your Reference Committee recommends that Resolution 816 be adopted.

(6) **RESOLUTION 825 – BURDENSOME PAPERWORK FOR BREAST PUMPS**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 825 be adopted.

HOD ACTION: Resolution 825 adopted.

Resolution 825 asks that our AMA vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions, and to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.

Strong support was heard on Resolution 825. Testimony highlighted instances in which insurance companies have imposed restrictions and created administrative barriers to obtaining breastfeeding equipment. Testimony emphasized that the Affordable Care Act requires insurance companies to cover breastfeeding supplies without co-payments, deductibles or co-insurance, so insurers who impose barriers are not in compliance with the law. Your Reference Committee concurs with testimony and recommends that Resolution 825 be adopted.

(7) **RESOLUTION 826 - TEMPORARY MEDICAL STAFF PRIVILEGES**

RECOMMENDATION:

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

HOD ACTION: Resolution 826 adopted.

Resolution 826 asks that our AMA support the use of temporary privileges in the following situations: (a) to fulfill an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a “clean” application is awaiting review and approval by the medical staff executive committee and the governing body; and work with other stakeholders to preserve the use of temporary privileges in the following situations: (a) to fulfill an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a “clean” application is awaiting review and approval by the medical staff executive committee and the governing body.

Supportive testimony was heard on Resolution 826. The sponsor of the resolution emphasized that the granting of temporary privileges has recently become more difficult, which is creating a barrier to accessing health care. Testimony emphasized that temporary privileges are granted when necessary to provide access to care and ensure patient safety. It was stressed that allowing for temporary privileges is especially important for rural and critical care hospitals. A concern about the qualifications of temporary medical staff was discussed and it was clarified that there is a process in place to check basic information, including licensure. A related amendment was offered, but your Reference Committee believes that the concern is adequately covered in the resolution. Your Reference Committee concurs with testimony that the AMA should support an expeditious process to grant temporary privileges and recommends that Resolution 826 be adopted.

(8) BOARD OF TRUSTEES REPORT 1 - PRINCIPLES FOR HOSPITAL SPONSORED ELECTRONIC HEALTH RECORDS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 1 be amended by addition and deletion on lines 31-33 to read as follows:

1. That our American Medical Association promote seek to prioritize electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 1 be amended by addition of a new Recommendation to read as follows:

That our AMA advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 1 be amended by addition of a new Recommendation to read as follows:

That our AMA advocate that medical practices are the ultimate custodians of individual and aggregate patient information and should have unfettered access to their data.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation C referred with report back at the 2016 Annual Meeting. The remainder of the recommendations in Board of Trustees Report 1 adopted as amended and the remainder of the report filed.

Board of Trustees Report 1 recommends that our AMA seek to prioritize electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process; work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production; and work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.

Generally positive testimony was heard on Board of Trustees Report 1, with several suggested amendments. It was suggested that Recommendation 1 replace “seek to prioritize” with “promote” and replace “certification process” with “highest priority.” Your Reference Committee agrees that the word “promote” is more appropriate because as noted in testimony, it is difficult to prioritize EHR interoperability when it does not yet exist.

Two additional recommendations were suggested so that physicians can maintain access to their patient data regardless of changes in their EHR system. Your Reference Committee recommends that the recommendations in Board of Trustees Report 1 be adopted as amended.

(9) COUNCIL ON MEDICAL SERVICE REPORT 2 - PHARMACEUTICAL COSTS
 RESOLUTION 806 - ABUSE OF FREE MARKET PHARMA
 RESOLUTION 814 - ADDRESSING THE RISING PRICE OF PRESCRIPTION DRUGS
 RESOLUTION 817 - HIGH AND ESCALATING PRESCRIPTION DRUG PRICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 2 be amended by substitution to read as follows:

4. That our AMA encourage Federal Trade Commission actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 8 in Council on Medical Service Report 2 be amended by addition on line 8 to read as follows:

8. That our AMA encourage prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 10 in Council on Medical Service Report 2 be amended by deletion on line 37 to read as follows:

10. That our AMA support legislation to shorten the ~~market~~ exclusivity period for biologics.

RECOMMENDATION D:

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

That our AMA reaffirm Policy D-330.954, which states that our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs, and work toward eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)

RECOMMENDATION E:

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

That our AMA reaffirm Policy H-110.992, which states that our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)

RECOMMENDATION F:

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

That our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.

RECOMMENDATION G:

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

That our AMA generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the

rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting

RECOMMENDATION H:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended in lieu of Resolutions 806, 814 and 817 and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 adopted as amended in lieu of Resolutions 806, 814 and 817 and the remainder of the report filed.

Council on Medical Service Report 2 contains recommendations to improve the affordability of generic drugs, brand-name drugs, and biologics.

Resolution 806 asks that our AMA advocate that the appropriate regulatory bodies of the federal government exercise its “march-in-rights” authority under the Bayh-Dole Act to assure the availability of pharmaceuticals at fair and reasonable prices to consumers, and reaffirm AMA policy in support of advocating that Medicare be granted the right to negotiate drug prices with pharmaceutical companies.

Resolution 814 asks that our AMA convene a task force of all of the relevant stakeholders in the development, approval, and cost of prescription drugs, which should include representation from physicians, physician researchers, the pharmaceutical industry, pharmacy benefit managers, insurance payers, the Centers for Medicare & Medicaid Services, the US Food and Drug Administration, hospitals, and patient advocates; generate a grassroots effort to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and helps to put forward solutions to make prescription drugs more affordable for all patients; and report back to the HOD regarding the progress of the drug pricing task force and grassroots effort at the 2016 Interim meeting.

Resolution 817 asks that our AMA work diligently and actively with Congress to advance legislation that would allow the Department of Health and Human Services to negotiate with pharmaceutical manufacturers the prices that may be charged for covered Medicare Part D drugs; and seek and actively support measures that would increase transparency in how pharmaceutical companies, pharmacy benefit managers, and health insurance companies determine the costs of prescription medications, including increasing transparency related to any incentives given by drug companies to pharmacy benefit managers or health insurance companies related to the dispensing or promotion of their manufactured drugs.

There was generally supportive testimony on Council on Medical Service Report 2. A member of the Council on Medical Service introduced the report, and proposed substitute language for the fourth recommendation of the report to clarify its intent, which your Reference Committee accepted in Recommendation A. Many speakers, in speaking in favor of the recommendations in Council on Medical Service Report 2, stated that the AMA has to take steps to be more aggressive on this issue, and spoke in favor of both Resolutions 814 and 817. Recommendations B, D and E incorporate the intent of Resolution 817 as amendments to Council on Medical Service Report 2. Your Reference Committee believes that amending the eighth recommendation of the Council report, as called for in Recommendation B, to specifically reference pharmaceutical companies, pharmacy benefit managers and health insurance companies will help patients, physicians and other stakeholders understand how drug and biologic manufacturers set prices, and the prescription drug tiering and cost-sharing requirements of health plans. Recommendations B and E address the intent of the second resolve of Resolution 817. Recommendation D addresses the intent of the first resolve of Resolution 817; your Reference Committee notes that Policy D-330.954, includes two strong directives for AMA action: to support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs, and to work toward eliminating Medicare prohibition on drug price negotiation. The policy also enables the

AMA to engage on this issue as the interest among members of Congress continues to increase, and as Congressional hearings are held on the topic of drug pricing.

In addition, another member of the Council on Medical Service noted the Council's agreement with the intent of the second resolve clause of Resolution 814, to use the AMA's strong policy foundation on prescription drug pricing to generate an advocacy campaign on the issue. As such, your Reference Committee addressed the intent of the second and third resolve clauses of Resolution 814 in Recommendation G. However, members of the Council on Medical Service and Council on Legislation noted that the recently announced HHS Pharmaceutical Forum, taking place November 20, addresses the intent of the first resolve clause of Resolution 814 that calls for the AMA to convene a task force on the issue of drug pricing. There were also concerns raised with the cost of the AMA convening a task force of the stakeholders listed in Resolution 814, as well as its return on AMA's investment. Instead, as a middle ground, some speakers stated that the AMA can convene a task force of physicians, made up of appropriate Councils and state and medical specialty societies. Speakers stressed that this approach will not only ensure that physicians have a voice at the table, but will facilitate a collaborative effort within the Federation in coming up with principles to drive AMA advocacy and grassroots efforts, based on AMA's strong and comprehensive policy foundation on the issue of drug pricing. Your Reference Committee agrees, and as such puts forward Recommendation F for adoption. Based on the testimony on this item at the hearing, your Reference Committee believes that eliminating the Medicare prohibition on drug price negotiation should be considered by the task force as a potential principle for advocacy efforts.

Your Reference Committee heard mixed testimony on Resolution 806. A member of the Council on Medical Service stated that the resolution would have unintended consequences and severely disrupt the functionality of and innovation in the pharmaceutical marketplace. The Council member stressed that march-in rights have never been exercised by the federal government, and that the factors are hard to establish to justify the exercise of march-in rights. Additional speakers raised concerns with Resolution 806, especially as it pertains to supporting federal government intervention in the pharmaceutical marketplace, which may stymie innovation. Your Reference Committee agrees that the resolution would have unintended consequences, and the recommendations of the Council report, as well as the intent of Resolutions 814 and 817, more effectively address the issue.

A speaker from PhRMA, in raising the organization's concerns with CMS Report 2 as well as Resolutions 806, 814 and 817, highlighted a difference in statutory interpretation of the Affordable Care Act pertaining to market versus data exclusivity of biologics. A member of the Council on Medical Service outlined AMA's interpretation of the ACA pertaining to the exclusivity period afforded to innovator biologics. There is also a difference between stakeholders in how the term "market exclusivity" is defined, which is included in the tenth recommendation of the Council on Medical Service Report 2. Your Reference Committee understands that the intention of this recommendation is to reduce the market exclusivity that an innovator biological has relative to a follow-on biosimilar, not as PhRMA suggested relative to a competing innovator biological. However, to reduce confusion with definitions, your Reference Committee recommends striking the word "market" in Recommendation 10 of Council on Medical Service Report 2, as outlined in Recommendation C. Overall, your Reference Committee recommends that Council on Medical Service Report 2 be adopted as amended in lieu of Resolutions 806, 814 and 817.

D-330.954 Prescription Drug Prices and Medicare

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. 2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.

H-110.992 Study of Actions to Control Pharmaceutical Costs

Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs.

(10) COUNCIL ON MEDICAL SERVICE REPORT 4 - PARITY OF PAYMENT FOR ADMINISTERING BIOLOGIC MEDICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 of Council on Medical Service Report 4 be amended by deletion to read as follows:

3. That our AMA support and encourage interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions ~~for rheumatic conditions~~.

RECOMMENDATION B:

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

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

Council on Medical Service Report 4 recommends that our AMA reaffirm Policies H-390.921 and H-70.919, and support and encourage interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions for rheumatic conditions.

Limited testimony was heard on Council on Medical Service Report 4. An amendment suggested broadening Recommendation 3 to include medical conditions beyond rheumatic conditions in order to be more inclusive. The Council on Medical Service agreed with this edit. Your Reference Committee recommends that Council on Medical Service Report 4 be adopted as amended.

(11) COUNCIL ON MEDICAL SERVICE REPORT 5 - PHYSICIAN EMPLOYMENT TRENDS AND PRINCIPLES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 5 be amended by addition on page 6, lines 28-29 to read as follows:

That our AMA encourage continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.

RECOMMENDATION B:

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

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

Council on Medical Service Report 5 recommends that our AMA reaffirm Policy H-385.926[2]; encourage physicians who seek employment as their mode of practice to strive for employment arrangements consistent with outlined principles; encourage continued research on the effects of integrated health care delivery models on patients and the medical profession; and rescind Policy D-225.976.

There was supportive testimony on this report. Testimony suggested adding a recommendation requesting that, in light of the Congressional budget provision prohibiting off-campus, provider-based facility acquisition by hospitals, the Council continue monitoring physician employment and report back on the status of the marketplace at the 2016 Annual Meeting. While your Reference Committee recognizes the need for continued research on this issue, your Reference Committee notes that the provision referenced does not take effect until 2017 and believes it is unclear if there will be changes in the physician employment landscape justifying a second Council report on this topic at the 2016 Annual Meeting. Additional testimony suggested adding reference to employed physicians in Recommendation 3, and your Reference Committee believes this amendment more accurately defines the intended scope of further research. Several speakers and your Reference Committee commend the Council on its thoughtful report. As such, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

(12) COUNCIL ON MEDICAL SERVICE REPORT 6 - HEARING AID COVERAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 6 be amended by addition and deletion on page 5, line 6 to read as follows:

3. That our AMA support public and private health insurance coverage that provides all hearing-impaired infants and children with hearing loss access to appropriate physician-led teams, hearing health professionals, services and devices, including digital hearing aids.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be amended by addition of a new Recommendation to read as follows:

6. That our AMA support coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Annual Wellness Benefit.

RECOMMENDATION C:

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

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

Council on Medical Service Report 6 recommends that our AMA reaffirm Policies H-245.970 and H-165.846; support public and private health insurance coverage that provides all infants and children with hearing loss access to appropriate hearing health professionals, services and devices, including digital hearing aids; support hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear; and encourage private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.

Testimony was generally supportive of Council on Medical Service Report 6. Testimony called for an amendment requesting that hearing aid clinical trials be covered by Medicare. Your Reference Committee believes that such an amendment is beyond the scope of this report. Additional testimony requested challenging the technology industry to invent the use of less expensive devices. While your Reference Committee appreciates the goal of the clinical trial amendment, your Reference Committee does not find this amendment to be germane to this report.

An amendment was offered, and the Council accepted, to change “professionals” in Recommendation 3 to “physician-led teams” recognizing the importance and involvement of the physician-led health care team. Your Reference Committee recommends this amendment to not only mitigate scope of practice concerns but also serve the interest of the patient. Another speaker offered an amendment to include supporting coverage for hearing tests administered by a physician or physician-led team as part of Medicare’s Annual Wellness Benefit. Your Reference Committee concurs with this amendment.

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

(13) COUNCIL ON MEDICAL SERVICE REPORT 7 - INCORPORATING COMMUNITY HEALTH WORKERS INTO THE US HEALTH CARE SYSTEM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 7 be amended by addition on page 7, line 27 to read as follows:

3. That our AMA encourage states and other appropriate stakeholders to conduct background checks on community health workers prior to the community health worker providing services and take the background check results into appropriate consideration.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA encourage states and other appropriate stakeholders to engage in collaborative efforts with community health workers and their professional organizations in the development and implementation of policies related to community health workers.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA encourage states to consider privacy and liability issues related to the inclusion of community health workers in the physician-led health care team.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7
adopted as amended and the remainder of the report filed.

Council on Medical Service Report 7 contains recommendations to help define the appropriate role of community health workers as part of a patient's health care team.

There was mixed testimony on this report. While numerous speakers stated that the report provides foundational policy on this emerging workforce, several speakers called for referral of the report. Several speakers expressed concern on the proper utilization of background checks, and your Reference Committee suggests an amendment to Recommendation 3 encouraging that the results of background checks be given appropriate consideration. Your Reference Committee believes this amendment recognizes that community integration and experience are defining characteristics qualifying individuals to work as community health workers.

Several speakers recommended referral due to concern around community health worker self-determination. To address this concern, your Reference Committee offers an additional recommendation supporting the principle that policies related to community health workers be developed in collaboration with these workers and their professional organizations.

Your Reference Committee heard testimony reflecting privacy and liability concerns related to the work of community health workers. Your Reference Committee agrees with testimony by the Council that liability issues largely will be addressed at the state-level. However, your Reference Committee appreciates the concern of privacy and liability issues and therefore recommends adding an additional recommendation encouraging states to address these issues to mitigate concern.

Your Reference Committee is aware that the use of community health workers is increasing and believes that the guidelines developed by the Council and proffered amendments provide a solid policy foundation to ensure that community health workers help facilitate and improve access to care. Further, your Reference Committee believes the Council will revisit other concerns related to community health workers as such issues arise. Accordingly, your Reference Committee recommends that Council on Medical Service Report 7 be adopted as amended and the remainder of the report filed.

(14) RESOLUTION 807 - THIRD PARTY PAYER COVERAGE PROCESS REFORM AND ADVOCACY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Substitute Resolution 807 be adopted.

IMPROVING THE LOCAL COVERAGE DETERMINATION PROCESS

RESOLVED, That our American Medical Association advocate through legislative and/or regulatory efforts as follows:

- a. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) that restrict coverage, said Contractors must: 1. Ensure that ~~Conduct~~ Carrier Advisory Committee meetings in public, ~~with~~ minutes are recorded and posted to the Contractor's website; and 2. Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD;
- b. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and
- c. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction; and be it further

RESOLVED, That our AMA work with interested state medical and national specialty societies to develop model legislation or regulations requiring

commercial insurance companies, state Medicaid agencies, or third party payers to:

- a. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and
- b. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.

HOD ACTION: Substitute Resolution 807 adopted as amended.

Resolution 807 asks that AMA Policy D-185.986 be amended by addition to include language stating that our AMA will advocate through legislative and/or regulatory efforts: 1) in support of outlined criteria governing the adoption and reconsideration of Local Coverage Determinations (LCDs) by Medicare Administrative Contractors (MACs); 2) that CMS adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party empowered to make recommendations to affirm, withdraw or revise said policies to the Secretary of HHS; and 3) that MACs be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.

There was supportive testimony on this resolution. Testimony stated and your Reference Committee agrees that this is a timely item. Additionally, your Reference Committee believes this issue is significant and warrants a separate policy to highlight the issue of local coverage determinations and recommends a title to accurately reflect the substitute resolution. Testimony suggested adding additional language to increase the transparency of unpublished and potentially unfair edits of LCDs and request that all payers participate in a transparent process. Your Reference Committee concurs with this suggestion. Accordingly, your Reference Committee recommends adoption of Substitute Resolution 807.

(15) RESOLUTION 809 - INDIVIDUAL RISK RATING FOR PUBLICLY-FUNDED HEALTH INSURANCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 809 be amended by addition and deletion on line 13 to read as follows:

RESOLVED, That our American Medical Association advocate that work to require Medicare, Medicaid, Disability and other publicly-funded health insurance programs to incentivize voluntary healthy behaviors among their participants which may decrease the cost of their medical care to the tax-paying public.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 809 be changed to read as follows:

PUBLICLY-FUNDED PROGRAMS INCENTIVIZING HEALTHY BEHAVIORS

RECOMMENDATION C:

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

HOD ACTION: Resolution 809 adopted as amended.

Resolution 809 asks that our AMA work to require Medicare, Medicaid, Disability and other publicly-funded health insurance programs to incentivize voluntary healthy behaviors among their participants which may decrease the cost of their medical care to the tax-paying public.

Supportive testimony was heard on Resolution 809. Your Reference Committee suggests replacing “work to require” with “advocate” so that the AMA can more broadly support this concept and suggests a title change to better reflect the intent of Resolution 809. Your Reference Committee recommends that Resolution 809 be adopted as amended.

(16) RESOLUTION 811 - HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY FOR HOSPITAL-BASED PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Substitute Resolution 811 be adopted.

~~RESOLVED, That our AMA reaffirm Policy H 285.911, which states that our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers for all medically necessary and emergency care at the preferred, in network benefit level on a timely and geographically accessible basis (Reaffirm HOD Policy); and be it further~~

RESOLVED, That American Medical Association Policy H 285.908, Network Adequacy, be amended by addition to read as follows:

H-285.908 Network Adequacy

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant’s annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.

8. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.

9. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

10. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy, including hospital-based physician specialties (i.e., radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.

RESOLVED, That our AMA support health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. Any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.

HOD ACTION: Substitute Resolution 811 adopted as amended.

Resolution 811 asks that AMA Policy H-285.908 be amended by addition to include language calling for our AMA to advocate that health plans be required to document to regulators that they have met requisite standards of network adequacy for hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities.

There was generally supportive testimony on Resolution 811. However, a member of the Council on Medical Service noted that Resolution 811 may have unintended consequences, as requiring health plans to document to regulators that they have met requisite standards of network adequacy for hospital-based physician specialties at in-network facilities may lead hospitals and health plans to mandate that all hospital-based physician specialties be in network, undermining the ability of these physicians to negotiate their charges. As an alternative, the Council member suggested reaffirmation of Policy H-285.911, which your Reference Committee agrees includes hospital-based specialties. There was also strong support for an amendment offered by the New York delegation concerning payment for out-of-network services. Your Reference Committee believes that the amendment only strengthens AMA's policy foundation on network adequacy and fair and equitable payment to out-of-network providers. Your Reference Committee notes that other amendments were offered to add and delete components of Policy H-285.908, but they were beyond the scope of the intent of Resolution 811. Your Reference Committee believes that Substitute Resolution 811 should be adopted.

H-285.911 Health Insurance Safeguards

Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis.

(17) RESOLUTION 818 - OPPOSE 2015 MEDICARE PROPOSED/DRAFT LOCAL COVERAGE DETERMINATION FOR LOWER LIMB PROSTHESES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Substitute Resolution 818 be adopted.

OPPOSE LOCAL COVERAGE DETERMINATION FOR LOWER LIMB PROSTHESES

RESOLVED, That our American Medical Association oppose local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access ; and be it further

RESOLVED, That our AMA request that the Centers for Medicare and Medicaid Services (CMS) expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients.

HOD ACTION: Substitute Resolution 818 adopted.

Resolution 818 asks that our AMA express strong opposition to the July 16, 2015 Proposed/Draft Local Coverage Determination (LCD) for Lower Limb Prostheses; and request the Centers for Medicare and Medicaid Services rescind the July 16, 2015 Proposed/Draft LCD for Lower Limb Prostheses and host a national meeting open to interested parties, including physicians trained in care of patients with amputations, prosthetists, patients including amputees, and other interested parties to focus on appropriate standards for lower limb prostheses that optimize care for our patients.

There was unanimous supportive testimony on this resolution. Your Reference Committee agrees with testimony that the proposed Local Coverage Determination (LCD) would eliminate or restrict coverage for many modern lower limb prostheses and replace them with outdated technology that has the practical effect of reducing the current standard of care. Because your Reference Committee believes this issue warrants enduring policy, it recommends broader substitute language deleting reference to the specific LCD at issue. Further, your Reference Committee notes that CMS is delaying the new prosthetics rule and convening a work group in 2016 to discuss the proposed LCD changes. As such, your Reference Committee recommends requesting that CMS expeditiously host a national meeting to garner stakeholder input. Accordingly, your Reference Committee recommends Substitute Resolution 818 be adopted in lieu of Resolution 818.

(18) RESOLUTION 821 - TRANSPARENCY OF HEALTH CARE PROVIDER PROFILES IN COMMERCIAL AND FEDERAL PHYSICIAN COMPARISON DATABASES

RECOMMENDATION A:

RESOLVED, That our American Medical Association encourage accurate and transparent listings of professional degree(s), post-graduate specialty education, and naming of the certifying agency with board certification data released to the public for comparison of healthcare providers or other healthcare services, in accordance with existing AMA policy. ; and be it further

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 821 be amended by addition and deletion on page 1, line 36 to read as follows:

RESOLVED, That our AMA urge commercial entities and federal programs providing healthcare provider ratings, comparisons, referrals, direct appointments, telehealth, or other services to revise the search and reporting methodology used for profiling of all healthcare providers so as to increase transparency requirements, including the description of professional degree(s), post graduate specialty education, and naming of the certifying board(s) , and the board credentials for physicians who are diplomats of the American Board of Medical Specialties (AMBS) or the American Osteopathic Association (AOA), in accordance with existing AMA policy.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 821 be adopted as amended.

HOD ACTION: Resolution 821 adopted as amended.

Resolution 821 asks that our AMA encourage accurate and transparent requirements for reporting of professional degree(s), post-graduate specialty education, and naming of the certifying agency with board certification data released to the public for comparison of healthcare providers or other healthcare services; and urge commercial entities and federal programs providing healthcare provider ratings, comparisons, referrals, direct appointments, telehealth, or other services to revise the search and reporting methodology used for profiling of all healthcare providers so as to increase transparency requirements, including the description of professional degree(s), post-graduate specialty education, and naming of the certifying board(s).

There was supportive testimony on this resolution. Several speakers noted the importance of accuracy and transparency in physician profiles. Following debate, substitute language was offered by the sponsor. However, your Reference Committee did not find the proposed language germane to the resolution. Additional testimony offered an amendment to further specify the board credentials of physicians, and your Reference Committee believes this amendment is appropriate. Your Reference Committee believes that it is critical that physician ratings be transparent to provide meaningful and accurate information to patients. As a note, your Reference Committee recommends a revised spelling of health care to reflect AMA style. Accordingly, your Reference Committee recommends adopting Resolution 821 as amended.

(19) RESOLUTION 822 - LYMPHEDEMA TREATMENT ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Substitute Resolution 822 be adopted.

MEDICARE COVERAGE FOR EVIDENCE-BASED LYMPHEDEMA TREATMENT

RESOLVED, That our American Medical Association support Medicare coverage for appropriate and evidence-based treatment of lymphedema.

HOD ACTION: Substitute Resolution 822 adopted.

Resolution 822 asks that our AMA advocate for the elements of H.R. 1608 to amend title XVIII of the Social Security Act that provide for Medicare coverage of certain lymphedema compression treatment items as items of durable medical equipment.

There was unanimous testimony in support of Resolution 822. Excellent detailed testimony requested amendments clarifying that compression garments are not items of durable medical equipment and requesting the inclusion of coverage for specific treatment options. Your Reference Committee believes its proposed language addresses these statements, provides for comprehensive evidence-based care of lymphedema, and accounts for treatment flexibility as technology progresses. Additional testimony suggested deleting reference to specific legislation for sustaining policy, and your Reference Committee concurs. Accordingly, your Reference Committee recommends that Substitute Resolution 822 be adopted.

(20) RESOLUTION 824 - DEFINING ANNUAL WELLNESS VISIT AS PROVIDED BY COMMUNITY-BASED PRIMARY CARE PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 824 be amended by addition to read as follows:

RESOLVED, That our American Medical Association continue to advocate for clear definition of the Centers for Medicare and Medicaid Services' Medicare Annual Wellness Visit as one that is provided only by physicians or members of a community-based, physician-led team that will provide continuity of care to those patients

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 824 be adopted as amended.

HOD ACTION: Resolution 824 referred.

Resolution 824 asks that our AMA advocate for clear definition of the Centers for Medicare and Medicaid Services' Medicare Annual Wellness Visit as one that is provided only by physicians or members of a community-based, physician-led team that will provide continuity of care to those patients.

There was supportive testimony on Resolution 824. A speaker noted that Medicare's annual wellness visit should only be provided by a primary care physician. However, your Reference Committee believes that the language of Resolution 824 is appropriate, and allows for a member of a physician-led team to also provide the annual wellness visit. The language is not inclusive of nurse practitioners and other health professionals to provide the annual wellness visit outside of a physician-led team. Your Reference Committee notes that the AMA has already advocated in favor of what is called for in Resolution 824, and therefore recommends that the language of the resolution be changed to call for the AMA to continue to advocate on this issue. First, the AMA joined with several national medical specialty societies whose members often provide the annual wellness visit in sending a letter to the Acting Administrator of the Centers for Medicare & Medicaid Services (CMS). Also, the AMA met with senior CMS officials following their receipt of the letter, and agency staff expressed appreciation to the physician community for bringing this issue to their attention. CMS indicated that it shares these concerns, particularly for Medicare patients who have a regular source of care that also provides their annual wellness visits.

(21) RESOLUTION 827 - MEDICATION BROWN BAGGING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Substitute Resolution 827 be adopted.

RESOLVED, That our American Medical Association work with interested specialty and state medical societies to oppose insurance plan policies and state legislative and regulatory actions that force patients to "brown bag" their medications.

HOD ACTION: Resolution 827 referred with report back at the 2016 Annual Meeting.

Resolution 827 asks that our AMA study the potential benefits and harms of medication "brown bagging," which is the practice of patients bringing their own medications into their physicians' offices or into hospitals for administration in those settings, with report back at the 2016 Interim Meeting.

Your Reference Committee heard generally supportive testimony on this resolution. Your Reference Committee agrees with testimony that the practice of "brown bagging" medications subjects physicians to risk because of the break in the chain of custody. Also, there are safety concerns with "brown bagging." For example, biologics have to be maintained under particular conditions, which in the practice of "brown bagging" would fail to the patient to ensure while the biologics are in transit. As such, rather than have the AMA study this issue, your Reference Committee believes that insurance plan policies, as well as state legislative and regulatory actions, that force patients to "brown bag" their medications should be opposed. Therefore, your Reference Committee recommends that Substitute Resolution 827 be adopted.

(22) RESOLUTION 804 - CONCURRENT HOSPICE AND CURATIVE CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 804 be referred.

HOD ACTION: Resolution 804 referred.

Resolution 804 asks that AMA Policy H-85.955 be amended by insertion to support changes in Medicare regulation to allow provision of concurrent curative and hospice care.

There was mixed testimony on this resolution. While testimony supported the concept of this resolution, some speakers voiced concern related to the confusion around not only coverage issues but also the terms palliative, curative, and hospice services. There was testimony suggesting a clarifying amendment to change “curative” to “disease-related.” However, additional testimony stated and your Reference Committee agrees that, despite the clarifying amendment, such care is complex and payment implications should be studied further. Accordingly, your Reference Committee recommends referral of Resolution 804.

(23) RESOLUTION 812 - PRESERVING PHYSICIAN/PATIENT RELATIONSHIPS DURING HOSPITALIZATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 812 be referred.

HOD ACTION: Resolution 812 adopted.

Resolution 812 asks that our AMA advocate that hospital admission processes include proposed principles; advocate that a medical staff incorporate the outlined principles into medical staff bylaws, rules and regulations; and request that the AMA Litigation Center be alert for opportunities to challenge and the Advocacy Resource Center study and address the trend of hospitals’ use of their employed hospitalists to limit the rights of their non-employed medical staff to admit and treat patients.

Positive testimony was heard on Resolution 812 urging the AMA to advocate for maintaining the patient-physician relationship when a patient is hospitalized. A member of the Council on Medical Service testified that the Council is currently studying this issue and suggested referral so the Council could incorporate the concerns raised by Resolution 812 in its forthcoming report. Your Reference Committee concurs that Resolution 812 should be referred.

(24) RESOLUTION 819 - PHYSICIAN AND MEDICAL STAFF MEMBER BILL OF RIGHTS

RECOMMENDATION:

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

HOD ACTION: Resolution 819 referred.

Resolution 819 asks that our AMA support and adopt the proposed medical staff member bill of rights; encourage state medical associations to promote the formation of medical staff advocacy committees throughout these states; and provide support for state medical associations in their efforts to aid medical staff advocacy committee’s role with medical staff issues and communications between physicians and hospitals and any other appropriate agency.

Mixed testimony was heard on Resolution 819. Some speakers favored adoption while others suggested referral. Your Reference Committee cautions that the length and detail of the proposed bill of rights is not something that should be adopted without a thorough review of each component and therefore recommends referral.

(25) RESOLUTION 813 - REMOVING FINANCIAL BARRIERS TO
PARTICIPATION IN CLINICAL TRIALS FOR MEDICARE
BENEFICIARIES
RESOLUTION 823 - H.R. 6 21ST CENTURY CURES ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 813 and 823 be referred for decision.

HOD ACTION: Resolutions 813 and 823 referred for decision with a request for an informational report back to the House of Delegates.

Resolution 813 asks that our AMA advocate for legislation providing Medicare beneficiaries with coverage for the full amount of Medicare approved expenses incurred through participation in approved clinical trials by: a) requiring Medicare to pay 100% of all of a beneficiary's Medicare approved costs of routine care and care for complications associated with approved clinical trials and not paid by Medicare or, if this proves unfeasible, a combination of b) and c) below; b) removing Medicare provisions that prohibit clinical trial sponsors from covering Medicare copays and deductibles; and/or c) requiring all Medigap supplement insurance policies to pay all of a beneficiary's Medicare approved costs of routine care and care for complications associated with approved clinical trials and not paid by Medicare or clinical trials sponsors.

Resolution 823 asks that our AMA advocate for the U.S. Senate to amend H.R. 6 21st Century Cures Act to prohibit all supplemental (Medigap) insurance policies (Parts B, C, and D) from denying coverage of the entire Medicare approved expenses for a FDA approved clinical trial that Medicare Part A does not cover; that the legislation be amended to allow sponsors of clinical trials to cover what supplemental insurance does not for those beneficiaries with supplemental insurance, as well as what supplemental insurance would have covered for those Medicare beneficiaries without Part B or Part C and/or Part D supplemental insurance or that in cases of Medicare and FDA approved clinical trials, Medicare be required to pay 100 percent of all Medicare approved expenses.

Testimony was mixed on Resolutions 813 and 823. Significant testimony stated that the issue of clinical trial insurance coverage was multi-pronged and complex. Several speakers stated the resolutions relate to complex coverage issues and raise potential coercion concerns. Your Reference Committee recognizes the complex nature of these resolutions. One speaker noted that a Senate committee is considering the issue of clinical trial coverage in January 2016. Therefore, because this issue is both complex and time-sensitive, your Reference Committee recommends that Resolutions 813 and 823 be referred for decision.

(26) RESOLUTION 808 - FIXING THE EMERGENCY TREATMENT
COVERAGE GAP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-130.978 and H-285.908 reaffirmed in lieu of Resolution 808.

HOD ACTION: Policies H-130.978 and H-285.908 reaffirmed in lieu of Resolution 808.

Resolution 808 asks that our AMA seek changes in federal law and regulations to require health insurers to publicly disclose their median in-network rate and the amount insurers pay for out-of-network emergency services, including active labor; and seek changes in federal law to require health insurers offering plans on ACA's health insurance exchanges to offer for purchase additional coverage to settle out-of-network claims for labor and delivery,

emergency care and any subsequent procedure or admission to the hospital at the preferred level of coverage based upon the charge submitted on the claim.

There was mixed testimony on this resolution. Speakers, including emergency physicians, stressed that there could be unintended consequences associated with the first resolve of the resolution, as having health insurers publicly disclosing their rates could cause collusion of contracted rates. The collusion in rates could cause a decrease, not increase, in payment for emergency services. Your Reference Committee believes that Policy H-130.978[3] would be a better approach to ensuring adequate and appropriate payment for out-of-network emergency services. The policy encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided. Your Reference Committee believes that the policy would allow emergency physicians to address the implementation of the ACA regulations addressing payment for out-of-network emergency services highlighted in Resolution 808. In addition, a member of the Council on Medical Service noted that Policy H-285.908[4], [5] and [6] address the intent of the second resolve of the resolution. The policy supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, as well as fair and equitable compensation to out-of-network providers, in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. Your Reference Committee agrees that the approach outlined in Policy H-285.908, along with ongoing AMA advocacy at the state and federal level addressing network adequacy, will be effective in ensuring that patients have meaningful access to medically necessary and emergency care at the preferred, in-network benefit level on a timely and geographically accessible basis, as well as ensure fair payment to out-of-network providers. As such, your Reference Committee recommends that Policies H-130.978 and H-285.908 be reaffirmed in lieu of Resolution 808.

H-130.978 Billing Procedures for Emergency Care

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) **Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.**

H-285.908 Network Adequacy

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements. 2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. 3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. 4. **Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.** 5. **Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward**

a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies. 6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 7. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. 8. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. 9. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

(27) RESOLUTION 815 - TELEMEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-480.946 be reaffirmed in lieu of Resolution 815.

HOD ACTION: Policy H-480.946 reaffirmed in lieu of Resolution 815.

Resolution 815 asks that our AMA telemedicine policy state that the use of telemedicine services for episodic care should be done within the context of the medical home; state that telemedicine encounters be linked to the medical records of the primary care medical home so that the medical home can coordinate the holistic care of the patient; and be shared with state and specialty medical societies and the Federation of State Medical Boards.

There was mixed testimony on Resolution 815. Several speakers highlighted concerns that Resolution 815 would limit telemedicine care provided by specialists and in emergency settings. Many specialties, including dermatologists, emergency physicians and radiologists have long used telemedicine to provide care, and many specialty societies have engaged in innovative initiatives to provide quality care via telemedicine. Additional speakers stressed that the provision of telemedicine services must include providing the patient's physician a copy of the medical record associated with the provision of the telemedicine service, and that the patient's medical history must be collected as part of the provision of any telemedicine service. Members of the Council on Medical Service and Council on Legislation noted that Policy H-480.946 already addresses the intent of Resolution 815. The policy, as well as AMA advocacy on this issue, stress that telemedicine should support care delivery that is patient centered, promotes care coordination, and facilitates team-based communication. Specifically, policy and AMA comment letters have stated that the provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physician(s) and providing to the latter a copy of the medical record. If a medical home does not exist, AMA policy and comments have stressed that telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

While amendments were offered to change the language of Resolution 815 to be more inclusive of specialists, your Reference Committee believes that Policy H-480.946 not only addresses the intent of Resolution 815, but also addresses the topics of the amendments offered to the resolution. Your Reference Committee notes that Policy H-480.946 was the product of a tremendous amount of work and negotiation among AMA Councils, as well as state and specialty societies, leading up to its adoption at the 2014 Annual Meeting. The language of Policy H-480.946 is inclusive of the patient's medical home and/or existing treating physicians, which includes specialists; respects evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies; recognizes the unique situations of providing services via telemedicine as a part of emergency medical treatment and on-call, cross coverage situations; and states that the provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record. Therefore, your Reference Committee recommends that Policy H-480.946 be reaffirmed in lieu of Resolution 815.

H-480.946 Coverage of and Payment for Telemedicine

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through: - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. **If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.** b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. e) The delivery of telemedicine services must be consistent with state scope of practice laws. f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit. g) The standards and scope of telemedicine services should be consistent with related in-person services. h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. **j) The patient's medical history must be collected as part of the provision of any telemedicine service. k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient. l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.** m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services. 2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine. 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

(28) RESOLUTION 820 - DE-LINKAGE OF MEDICAL STAFF PRIVILEGES
FROM HOSPITAL EMPLOYMENT CONTRACTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-225.950
be reaffirmed in lieu of Resolution 820.

HOD ACTION: Resolution 820 referred with report back at the 2016 Annual Meeting.

Resolution 820 asks that our AMA study and take appropriate action, up to and including pursuing federal legislation, to statutorily de-link/uncouple medical staff privileges from physician employment contracts, and report back to the House of Delegates at the 2016 Interim Meeting.

Your Reference Committee notes that there are circumstances in which physicians may rightfully be expected to automatically resign their medical staff membership and/or clinical privileges following termination of their employment agreements. For example, such resignation is common practice when a physician is under contract to provide some service on an exclusive basis, whether as an individual or as part of a special group.

Because physicians are increasingly entering into employment and other contractual relationships with hospitals, the AMA offers a variety of resources as identified in Council on Medical Service Report 5-A-15, "Hospital Incentives for Admission, Testing and Procedures." One such resource is the AMA's "Annotated Model Physician-Hospital Employment Agreement," which was developed to prepare physicians to negotiate an employment contract with a hospital or related entity.

In addition, Policy H-225.950 encourages physicians to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions, advocates for employment agreements to explicitly state if termination of the agreement is grounds for rescission of clinical privileges, and upon termination of employment with or without cause, the AMA maintains that an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

Your Reference Committee notes that the request to address medical staff privileges and employment contract concerns at the federal level may not be appropriate as it is a state issue. A member of the Council on Legislation testified that the Council recently adopted relevant model state legislation. One addresses due process protection concerning for cause termination and another addresses due process protection concerning without cause termination.

Since the AMA has relevant resources and existing policy that address physician employment and hospital privileges, your Reference Committee recommends that Policy H-225.950 be reaffirmed in lieu of Resolution 820.

REPORT OF REFERENCE COMMITTEE K

(1) COUNCIL ON MEDICAL EDUCATION REPORT 2 - RECONCILIATION OF MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION AND MAINTENANCE OF LICENSURE POLICIES

RECOMMENDATION:

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

**HOD ACTION: Recommendations in Council on Medical Education Report 2
adopted and the remainder of the report filed.**

Council on Medical Education Report 2 reviews and consolidates existing American Medical Association (AMA) policy on Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL) to ensure that these policies are current and coherent. No attempt was made to modify any existing policy beyond what was necessary for editing for clarity. The report recommends:

1.) That our American Medical Association (AMA) amend Policy H-275.924, Maintenance of Certification, by addition and deletion, to read as follows:

AMA Principles on Maintenance of Certification (MOC):

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by ~~each~~that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey ~~would~~are ~~neither~~not be appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. ~~The~~Our AMA affirms the current language regarding continuing medical education (CME): “~~By~~2011, ~~each~~Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part ~~2~~II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).”
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. ~~10.~~ MOC is ~~an essential but not sufficient but one~~ component to promote patient-care safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that ~~failures~~ ~~lapses~~ in patient safety are primarily failures of individual physicians.

12. ~~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.

13. ~~12.~~ The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. ~~13.~~ MOC should be used as a tool for continuous improvement.

15. ~~14.~~ The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment.

16. ~~15.~~ Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. ~~16.~~ MOC activities and measurement should be relevant to clinical practice.

19. ~~17.~~ The MOC process should not be cost prohibitive or present barriers to patient care.

20. ~~18.~~ Any assessment should be used to guide physicians' self-directed study.

21. ~~19.~~ Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. ~~20.~~ There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups:

2.) That our AMA adopt the following policy, Maintenance of Certification and Osteopathic Continuous Certification:

That our American Medical Association:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI® Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program;

3.) That our AMA amend Policy H-275.917, An Update on Maintenance of Licensure, by addition, to read as follows:

AMA Principles on Maintenance of Licensure (MOL):

1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:
 - A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
 - B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.
 - C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
 - D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
 - E. Any MOL activity should be designed for quality improvement and lifelong learning.
 - F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards (FSMB) Guiding Principles for MOL (current as of June 2015), which state that:

- A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
- B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
- C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
- D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
- E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).

3. That our AMA:

- A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.
- B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed.
- C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.
- D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence;

4.) That our AMA amend Policy D-275.957, An Update on Maintenance of Licensure, by addition and deletion, to read as follows:

That our American Medical Association (AMA):

- 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
- 2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
- 3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
- 4. Our AMA will work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
- 5. Our AMA will explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may be helpful tools to shape and support MOL for physicians.
- 6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
- 7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
- 8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time;

5.) That our AMA revise Policy H-275.926, Maintaining Medical Specialty Board Certification Standard, by addition and deletion, to read as follows:

That our American Medical Association (AMA):

- 1. Our AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association

Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

~~2. Our AMA will communicate its concerns about the misleading use of the term “board certification” by the National Board of Public Health Examiners and others to the specialty and service societies in the federation, the Association of Schools of Public Health, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the National Board of Medical Examiners, and the Institute of Medicine.~~

~~2.3. Our AMA will continue to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.~~

~~3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.~~

~~4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.~~

~~5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms;~~

6.) That the title of Policy H-275.926, Maintaining Medical Specialty Board Certification Standard, be revised to read as follows: Medical Specialty Board Certification Standards;

and (7) That our AMA rescind the following policies:

H-275.919, American Board of Medical Specialties Board Member Enrollment in Maintenance of Certification
H-275.920, Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce

H-275.923, Maintenance of Certification / Maintenance of Licensure

H-275.931, Representation on Medical Specialty Boards

H-275.932, Internal Medicine Board Certification Report--Interim Report

H-275.933, Specialty Board Recertification Requirements for Employment

H-275.944, Board Certification and Discrimination

H-275.950, Board Certification

H-405.970, Specialty Board Certification Fee Requirements

H-405.972, Recertification Alternatives

H-405.973, Board Certification

H-405.974, Specialty Recertification Examinations

H-405.975, Recertification Exam for the American Board of Medical Specialties

D-275.960, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure

D-275.961, Coordinated Efforts of Federation of State Medical Boards, American Board of Medical Specialties and American Osteopathic Association Regarding Maintenance of Licensure

D-275.969, Specialty Board Certification and Recertification

D-275.971, American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements

D-275.977, Update on the American Board of Medical Specialties Program on Maintenance of Certification (MOC)

D-275.987, Internal Medicine Board Certification Report - Interim Report

D-300.978, Continuing Medical Education Credit for Maintenance of Certification / Osteopathic Continuous Certification Activities

Your Reference Committee heard testimony, live and online, in support of CME Report 2. The goal of this report is to review and consolidate existing AMA policy on Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL) to ensure that these policies are current and coherent. It was noted that the purpose of policy consolidation is to make information on AMA policy more accessible and

improve the organization of our AMA policy database. The style of language may be different between items due to the merging of existing policies as originally adopted by our AMA. There was some contention on the distinction between “principles” and “policies.” The Council testified that it was not its intention to create a distinction between the two. No attempt was made to modify any existing policy beyond what was necessary for editing for clarity, currency, and consistency. Your Reference Committee therefore recommends adoption of CME Report 2.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 - NATIONAL DRUG SHORTAGES: UPDATE

RECOMMENDATION:

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

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

Council on Science and Public Health Report 2 provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue, and recommends amending current AMA policy. Several amendments are based on the fact that some previous sections of policy have been implemented or accomplished. The report recommends that Policy H-100.956 be amended by addition and deletion to read as follows:

H-100.956 National Drug Shortages

1. Our AMA supports the recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that experience drug shortages of the 2010 Drug Shortage Summit convened by the American Society of Health System Pharmacists, American Society of Anesthesiologists, American Society of Clinical Oncology and the Institute for Safe Medication Practices and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports requiring all manufacturers of Food and Drug Administration approved drugs and, including FDA approved drugs with recognized off label uses, to give the agency advance notice (at least 6 months prior or otherwise as soon as practicable) of anticipated voluntary or involuntary, permanent or temporary, discontinuance of the manufacture or marketing of such a product.
3. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA supports the creation of a task force to enhance the HHS Secretary's response to preventing and mitigating drug shortages and to create a strategic plan to: (a) enhance interagency coordination; (b) address drug shortage possibilities when initiating regulatory actions (including the removal of unapproved drug products from the market); (c) improve FDA's ability to track and analyze drug shortage data in an effort to develop strategies to better prevent drug shortages (d) provide further information on expedited solutions that have worked to prevent or mitigate drug shortages; (e) communicate with stakeholders; and (f) consider the impact of drug shortages on research and clinical trials.
5. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
6. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
7. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The Centers for Medicare & Medicaid Services should review and evaluate its 2003 Medicare

reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.

~~8. Our AMA urges that procedures be put in place: (1) for the FDA to monitor the availability of Schedule II controlled substances; (2) for the FDA to identify the existence of a shortage that is caused or exacerbated by existing production quotas; and, (3) for expedited DEA review of requests to increase aggregate and individual production quotas for such substances.~~

~~96.~~ Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

~~107.~~ Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

~~118.~~ Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

Appreciation was expressed for the work of the Council in keeping the House informed about drug shortages. Testimony also noted that AMA advocacy efforts continue to recognize the importance of addressing drug shortages and AMA policy parallels that of other Federation members. Based on existing measures, the number of drug shortages appears to be decreasing. Some speakers reinforced the fact that drug shortages continue to cause serious disruptions in patient care, and alternative, but less effective forms of treatment may be required. Certain sections of current policy were deleted because they have been accomplished by regulatory and legislative initiatives intended to address drug shortages. Your Reference Committee agrees that no simple solution exists for this problem, and upgrades in manufacturing capability, quality, and capacity will be needed to fix this problem, especially with respect to generic sterile injectables.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 -
COMBATING ANTIBIOTIC RESISTANCE: AN UPDATE

RECOMMENDATION:

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

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

Council on Science and Public Health Report 3 provides an overview of the global public health threat of antibiotic resistance and the range of actions being taken to address the problem, including actions physicians can take to promote the stewardship of current antibiotics. It recommends:

1.) That the following new policy be adopted:

Surveillance of Antibiotic Use and Resistance

Our AMA: (1) recognizes the importance of public health and veterinary health surveillance for antimicrobial resistance and antibiotic use; and (2) recommends that public health and veterinary health agencies be adequately funded, as outlined in the President's Council of Advisors on Science and Technology Report, to achieve the surveillance goals and objectives outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria;

2.) That Policy H-100.952 be amended by addition and deletion to read as follows:

H-100.952 Enhancing Antibiotic Stewardship in the Human Health Care Setting to Improve Patient Outcomes in the Inpatient Setting.

Our AMA will: (1) support antimicrobial stewardship programs, overseen by qualified physicians, as an effective way to ensure appropriate antibiotic use to reduce the burden of antimicrobial resistance, to optimize improve patient outcomes, and to reduce overall costs for a health care facilityies and systems. Antibiotic stewardship programs are systematic, multi-faceted, patient safety programs, and use evidence-based approaches to optimize antibiotic prescribing, encompassing components such as policy, guidelines, surveillance, education, epidemiology of current resistance, and process, and outcome measurement. Successful antibiotic stewardship programs monitor and direct antimicrobial use, providing a standard, evidence-based

approach to judicious antibiotic use in a healthcare facility across the spectrum of care, including, but not limited to acute care hospitals, outpatient clinics, emergency departments and long-term care facilities;

(2) support the development of antibiotic stewardship programs that allow flexibility so that adherence to national requirements does not limit the ability of providers to design programs based on local variables, such as health care facility size, patient population served, and care delivery setting (e.g., outpatient v. inpatient) and to address local antimicrobial stewardship and infection prevention challenges;

(3) urge each health care facility's governing body to promote and support robust, physician-led antimicrobial stewardship and infection prevention programs as critical components of assuring safe patient care; and

(4) support continued research into the impact of antibiotic stewardship programs on process outcomes and encourage increased research on the impact of such programs on patient-centered outcomes;

3.) That the following policies be reaffirmed:

H-100.953 Establishment of a Limited Population Antibacterial Drug Approval Pathway

H-100.960 The 10x 20 Initiative (10 New Antibiotics by 2020)

H-100.973 Combating Antimicrobial Resistance through Education

H-440.834 Next Generation Infectious Diseases Diagnostics

D-100.998 Combating Antibiotic Resistance Via Physician Action and Education: AMA Activities

H-440.846 Antibiotic Use in Food-Producing Animals;

and 4.) That the following directives be rescinded since they have been implemented:

D-100.995 Antimicrobial Use and Resistance

Our AMA will work with other organizations to establish a national program to counter antibiotic resistance in clinical practice similar to the California Medical Association Foundation AWARE program. (Res. 508, A-01; Reaffirmation I-07; Reaffirmation A-09)

D-440.991 Antimicrobial Use and Resistance

Our AMA will urge that increased surveillance of antimicrobial use and resistance be funded and instituted as recommended by the Institute of Medicine and American Society of Microbiology. (Res. 508, A-01; Reaffirmation A-09)

Fully supportive testimony was offered for the recommendations in the Council's report on the public health threat of antibiotic resistance. It was noted that the recommendations are fully aligned with the policies and activities of the Infectious Diseases Society of America. In particular, it is important that efforts to embrace antimicrobial stewardship be extended across all health care settings, not just hospitals.

(4) RESOLUTION 905 - EVALUATING GREEN SPACE INITIATIVES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 905 be adopted.

HOD ACTION: Resolution 905 adopted.

Resolution 905 asks that our American Medical Association support appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve patients' health and eliminate health disparities.

Your Reference Committee heard limited, but supportive testimony for Resolution 905. Evidence shows that increasing green space and parks increases physical activity and the proximity to green space has been shown to reduce socioeconomic health disparities. Your Reference Committee supports the resolution.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 1 - SOURCES OF FUNDING FOR GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 1 be amended by addition on page 6, line 46 to read as follows:

That our AMA explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

RECOMMENDATION B:

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

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

Council on Medical Education Report 1 examines funding sources for graduate medical education (GME). It recommends that our American Medical Association 1.) reaffirm Policy D-305.967 (8), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which advocates for continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of graduate medical education; 2.) explore various models of all-payer funding for GME, especially as the Institute of Medicine did not examine those options in its 2014 report on GME governance and financing; 3.) encourage all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; 4.) encourage organizations with successful existing models to publicize and share strategies, outcomes and costs; 5.) encourage insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME; and 6.) encourage entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Your Reference Committee heard both virtual and live testimony in support of the Council on Medical Education's exhaustive work in securing, maintaining and expanding our country's physician workforce. In light of the current unfavorable climate for expanded federal funding of GME, serious exploration of alternative funding sources is sorely needed and should include consideration of an all-payer system and federal-state partnerships. It was also expressed in testimony that funding innovations should be buttressed by a comprehensive national health care workforce strategy. Our AMA, through the Council on Medical Education, will continue its intense focus on this issue—for example, through collaboration with the Council on Legislation on its GME Compendium (currently under development). The Compendium will explore potential funding innovations. A minor editorial change was suggested, to indicate that the IOM is now a program of the National Academy of Medicine. Your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended.

**(6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 -
NONMEDICAL EXEMPTIONS TO IMMUNIZATION**

**RESOLUTION 904 - A NATIONAL CAMPAIGN TO IMPROVE
VACCINATION RATES**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Science and Public Health Report 1 be amended by addition and deletion on page 8, lines 4-18 to read as follows:

3.) That Policy H-440.830, Parent to Parent Education on Child Vaccination, be amended by substitution to read as follows:

Education and Public Awareness on Vaccine Safety and Efficacy

Our American Medical Association (1) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (2) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (23) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (34) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (45) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (56) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be adopted as amended in lieu of Resolution 904, and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 1 adopted as amended in lieu of Resolution 904, and the remainder of the report filed.

Council on Science and Public Health Report 1 updates the scientific literature on this topic and recommends consolidation and revisions to existing AMA policy on vaccines and immunizations, while maintaining strong support for the elimination of non-medical exemptions, in order to best protect public health. The report recommends:

1.) That Policy H-440.970, Religious Exemptions from Immunizations, be amended by substitution to read as follows:

Nonmedical Exemptions from Immunizations

Our American Medical Association (AMA) believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions from immunization; (3) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (4) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (5) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (6) recommends that states have in place: (a) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (b) policies that permit immunization exemptions for medical reasons only;

2.) That Policy H-440.831, Protecting Patients and the Public by Immunizing Physicians, be amended by substitution to read as follows:

Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization

1. American Medical Association (AMA) policy is that, in the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues or threatens the availability of the health care workforce, particularly a disease that has the potential to become epidemic or pandemic, including influenza, and for which there is an available, safe, and effective vaccine, physicians, health care workers (HCWs), and family caregivers who have direct patient care responsibilities or potential direct exposure have an obligation to accept immunization unless there is a recognized medical reason to not be immunized. In scenarios in which there is a documented medical contraindication to immunization of a physician or HCW, appropriate protective measures should be taken.
2. Our AMA (a) encourages hospitals, health care systems, and health care providers to provide immunizations to HCWs against influenza and other highly transmissible diseases, at no cost to the employee, both for their own protection and to reduce the risk of infectious disease transmission to others; and (b) encourages health care institutions to develop mechanisms to maximize the rate of influenza immunization for HCWs, including the option of making immunization a condition of employment;
- 3.) That Policy H-440.830, Parent to Parent Education on Child Vaccination, be amended by substitution to read as follows:

Education on Vaccine Safety and Efficacy

Our American Medical Association (1) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (2) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (3) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (4) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (5) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths; and
- 4.) That Policies H-440.850, Recommendations for Healthcare Worker and Patient Influenza Immunizations; D-440.936, Immunization Exemptions; D-440.947, Support for Immunizations; H-440.829, Ending Non-Medical Exemptions for Immunization; H-440.832, Vaccination Requirements to Protect All Children; and H-440.853, Increasing Public Awareness of the Lack of a Vaccine-Autism Link be rescinded since they have been implemented or accomplished (in the case of D-440.936 and H-440.853), or have been rendered duplicative by the recommendations in this report (in the case of D-440.850, D-440.947, and H-440.829).

Resolution 904 asks that our American Medical Association partner with appropriate stakeholders to sponsor a national, evidence-based public service announcement campaign aimed at increasing vaccination rates.

The Council reminded the audience that a joint report on vaccine exemptions with the Council on Ethical and Judicial Affairs was referred at the 2015 Annual Meeting, and that several resolutions related to vaccine exemptions were adopted at the same meeting. Overwhelmingly supportive testimony was offered for the Council's report and recommendations. The Council was congratulated for its science-based approach to the report and its strong stance on non-medical exemptions. Your Reference Committee believes that the Council's report appropriately focuses on the public health benefit of limiting exemptions, and supports the report's recommendations. Mixed testimony was offered on Resolution 904. While many believe that the public should be hearing messages that strongly support vaccination and its public health benefits, others believed that the cost to the AMA of spearheading such a campaign would be prohibitive. Public awareness campaigns have been made available by the Centers for Disease Control and Prevention for others to use. The Council offered an amendment to Recommendation 3 that captures the spirit of resolution 904 and which garnered support. Your Reference Committee therefore recommends incorporating encouragement for public awareness campaigns into Recommendation 3 of the Council report.

(7) RESOLUTION 902 - EDUCATING AMERICANS ON GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 902 be amended by addition to read as follows:

RESOLVED, That our American Medical Association explore the feasibility of developing, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 902 be adopted as amended.

HOD ACTION: Resolution 902 adopted as amended.

Resolution 902 asks that our American Medical Association develop a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

Your Reference Committee heard testimony in support of the need to educate the public regarding the importance of funding graduate medical education (GME) to help meet the health care needs of the nation. Much of this work is occurring through our AMA's SaveGME website, a reliable resource that is specifically targeted at lawmakers and students. This public awareness campaign provides information and fact sheets on the importance of GME funding and provides a mechanism to contact elected officials. It should be noted that current policy already directs our AMA to improve public awareness of GME. Further, the Council on Medical Education is preparing a report on the value of residents and fellows to the health care system for the 2016 Annual meeting. Despite these ongoing efforts, your Reference Committee heard testimony calling for adoption of Resolution 902, as GME funding is the "lifeblood" of the next generation of physicians, and public support in this arena is vital. It was also noted in testimony that such a campaign could have the additional benefit of reinforcing the AMA's work in scope of practice, to augment the public's understanding of the role of physicians in providing the highest quality of patient care. Due to the high fiscal note for this item, our AMA should seek partners to conduct this national campaign, as reflected in the revised language proffered above. This language reflects testimony from the Council on Medical Education, which recommended that this work be undertaken, with our AMA's lead, by the entire house of medicine. Therefore, your Reference Committee recommends that Resolution 902 be adopted as amended.

(8) **RESOLUTION 906 - IMPLEMENTING MEDICATION REMINDER SYSTEMS**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-373.933 be amended by addition and deletion to read as follows:

H-373.993 Medication Adherence in Patients with Low Health Literacy

Our AMA supports third parties in researching the effectiveness of personalized medication cards and other tools, including electronic reminders, intended to promote safe medication use, written in a variety of languages for low literacy target audiences, to achieve increased improve medication adherence, and improved health outcomes. Reminders should also be available in a variety of languages. Special attention should be devoted to reaching low literacy target audiences.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-373.933 be adopted in lieu of Resolution 906.

HOD ACTION: Amended Policy H-373.933 adopted in lieu of Resolution 906.

Resolution 906 asks that our American Medical Association support research into the efficacy of electronic medication reminder systems.

Strong support was offered for this resolution and the need to more broadly implement tactics that could improve medication adherence and patient outcomes. Your Reference Committee believes that amending current policy to place this approach among other potential ways to improve medication adherence is appropriate.

(9) RESOLUTION 907 - MAXIMIZING PATIENT OUTCOMES THROUGH PUBLIC ACCESS TO ALL PAST, PRESENT, AND FUTURE CLINICAL TRIALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 907 be amended by addition on page 2, line 8 to read as follows:

RESOLVED, That our American Medical Association support the timely dissemination of clinical trial data for public accessibility as permitted by research design and/or regulatory protocol ; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 907 be deleted.

RESOLVED, That our AMA sign the petition titled “All Trials Registered; All Results Reported” at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports ; and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 907 be amended by addition and deletion on page 2, lines 14-17 to read as follows:

RESOLVED, That our AMA support the promotion of improved data sharing, and the reaffirmation and enforcement of deadlines for submitting results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data ; and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 907 be adopted as amended and Policies H-460.912 and D-460.970 be reaffirmed.

HOD ACTION: First, third and fourth Resolves of Resolution 907 adopted as amended, second Resolve referred for decision, and Policies H-460.912 and D-460.970 reaffirmed.

Resolution 907 asks that our American Medical Association 1.) support the timely dissemination of clinical trial data for public accessibility; 2.) sign the petition titled “All Trials Registered; All Results Reported” at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports; 3.) support the promotion of improved data sharing, the reaffirmation and enforcement of deadlines for submitting

results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data; and 4.) encourage the expansion of clinical trial registrants to ClinicalTrials.gov.

Mostly supportive testimony was offered for Resolution 907. The importance to the medical community of having access to both positive and negative trial data was underscored, as were the potential knowledge gains that can arise from pooling research data and allowing others to objectively interpret it. Testimony noted, however, that the AllTrials.net initiative is somewhat new in this country, and it would be imprudent for our AMA to sign onto a petition that has not been reviewed for its potential to confer obligations or transfer risk to our AMA. Further, some concern was expressed about creating a global alliance to oversee data sharing policies. Your Reference Committee concurs with the importance of clinical trial data access, but shares the concern of those who expressed hesitation for signing onto a petition, as well as the creation of a global alliance. It therefore recommends amendments to the resolution to remove the petition-signing request and the reference to the global alliance. To address concerns about research subject confidentiality, your Reference Committee further recommends that public access to trial data be permitted according to research design and/or regulatory protocol.

Policies recommended for reaffirmation:

H-460.912 Principles for Conduct and Reporting of Clinical Trials

Our AMA: (1) endorses the Association of American Medical Colleges' "Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials"; and (2) commends the AAMC, the Centers for Education and Research in Therapeutics and the BlueCross BlueShield Association for the development and dissemination of these principles.

D-460.970 Access to Clinical Trial Data

Our AMA: (1) urges the Food and Drug Administration to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; and (2) supports the adoption of universal policy by medical journals requiring participating investigators to have independent access to all study data from industry-sponsored trials.

(10) RESOLUTION 909 - STUDY OTC AVAILABILITY OF NALOXONE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 909 be amended by addition and deletion on lines 23-24 to read as follows:

RESOLVED, That our American Medical Association support the study of encourage manufacturers or other qualified sponsors to pursue the application process for over the counter approval availability of naloxone with the Food and Drug Administration.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 909 be amended by addition of a second Resolve to read as follows:

RESOLVED, That our American Medical Association study and report back at A-16 on ways to expand the access and use of naloxone to prevent opioid-related overdose deaths.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 909 be adopted as amended.

HOD ACTION: Resolution 909 adopted as amended.

Resolution 909 asks that our American Medical Association support the study of over the counter availability of naloxone.

Strong support was offered for this resolution and for improving access to naloxone to prevent overdoses from opioid analgesics and heroin. Some support also was offered for referral. While this resolution seeks to specifically promote the concept of OTC availability of naloxone, this can be accomplished in a variety of ways. Naloxone is currently available without a prescription in several states through the use of a physician standing order or collaborative practice agreement. Conventional OTC access without the intervention of a health care professional would require a sponsor to conduct a study and submit an application to the FDA demonstrating that conditions of safe use could be established under this scenario. Testimony noted that one concern with standard OTC access might be lost opportunities for education and counseling. In the absence of data about the feasibility of standard OTC access, your Reference Committee supports an amendment that would express AMA support for investigating this approach, while also developing a report to more fully inform the House about ways to expand access to naloxone and save lives.

(11) RESOLUTION 911 - MAINTENANCE OF CERTIFICATION ADVOCACY
BY OUR AMERICAN MEDICAL ASSOCIATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 911 be amended by deletion of the first Resolve.

~~RESOLVED, That our American Medical Association actively support only those maintenance of certification programs administered by the specialty boards of the American Board of Medical Specialty (ABMS), or of any other similar physician certifying organization, which adhere to the 20 Principles codified as AMA Policy in AMA Policy H 275.924, Maintenance of Certification.; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve in Resolution 911 be amended by deletion on page 1, line 34-35 to read as follows:

~~RESOLVED, That our AMA oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the 20 Principles codified as AMA Policy on in AMA Policy H 275.924, Maintenance of Certification ; and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 911 be amended by deletion of the third Resolve.

~~RESOLVED, That our AMA communicate with ABMS, its member Specialty Boards, and any other similar physician certifying organization, its position to support only those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar certifying organization, which adhere to the 20 Principles codified as AMA Policy in AMA Policy H- 275.924, Maintenance of Certification, to assure elimination of any future miscommunication by the ABMS to the public or participating physicians..~~

RECOMMENDATION D:

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

HOD ACTION: Resolution 911 adopted as amended.

Resolution 911 asks that our American Medical Association 1.) actively support only those maintenance of certification programs administered by the specialty boards of the American Board of Medical Specialties (ABMS), or of any other similar physician certifying organization, which adhere to the 20 Principles codified as AMA Policy in AMA Policy H-275.924, Maintenance of Certification; 2.) oppose those maintenance of certification programs administered by the specialty boards of the (ABMS), or of any other similar physician certifying organization, which do not appropriately adhere to the 20 principles codified as AMA Policy in AMA Policy H-275.924, Maintenance of Certification; and 3.) communicate with ABMS, its member specialty boards, and any other similar physician certifying organization, its position to support only those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar certifying organization, which adhere to the 20 principles codified as AMA Policy in AMA Policy H-275.924, Maintenance of Certification, to assure elimination of any future miscommunication by the ABMS to the public or participating physicians.

Your Reference Committee heard testimony, live and online, in support of Resolution 911. Our AMA has developed extensive policy on maintenance of certification (MOC) and supports the intent of this program. This policy reinforces the need for ongoing learning and practice improvement and supports our AMA Principles on MOC. During testimony the ABMS noted that the specialty boards are looking at ways to restructure MOC to provide for greater transparency, flexibility, and innovations. It was noted that the policies listed in CME Report 2-I-15, Reconciliation of Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure Policies, already support the first and third Resolves. The Report also extends the number of principles under policy H-275.924 to 25 rather than 20. To avoid confusion, the number of principles was deleted. Given the testimony in favor of this item, your Reference Committee recommends adoption of Resolution 911 as amended.

(12) RESOLUTION 915 - RESIDENT AND FELLOW PHYSICIAN HEALTH AND WELLNESS REPORT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 915 be amended by deletion of the first Resolve.

~~RESOLVED, That our American Medical Association support educational initiatives to raise awareness about burnout, including but not limited to depression and suicide prevalence, among resident and fellow physicians ; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 915 be amended by deletion of the second Resolve.

~~RESOLVED, That our AMA collaborate with the Accreditation Council for Graduate Medical Education (ACGME), Commission on Osteopathic College Accreditation (COCA), and other interested parties to promote training for residency and fellowship programs on recognizing, screening, and intervening in cases of resident and fellow physician burnout ; and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 915 be amended by deletion of the third Resolve.

~~RESOLVED, That our AMA collaborate with the ACGME, COCA, and other interested parties to assist residency and fellowship programs in developing resident and fellow physician wellness initiatives ; and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 915 be amended by deletion of the fourth Resolve.

~~RESOLVED, That our AMA promote a culture of resident physician wellness within physician training programs ; and be it further~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 915 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA promote confidential, and accessible, and affordable mental health services for medical students and resident and fellow physicians

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Resolution 915 be amended by deletion of the sixth Resolve.

~~RESOLVED, That our AMA encourage further research on the causal factors of resident and fellow physician burnout and its sequelae, including but not limited to its effect on quality of healthcare delivery and patient health outcomes..~~

RECOMMENDATION G:

Madam Speaker, your Reference Committee recommends that Resolution 915 be adopted as amended and Policies D-320.968 and H-310.912 be reaffirmed.

RECOMMENDATION H:

Madam Speaker, your Reference Committee recommends that the title of Resolution 915 be changed.

MENTAL HEALTH SERVICES FOR MEDICAL STUDENTS AND RESIDENT AND FELLOW PHYSICIANS

HOD ACTION: Resolution 915 adopted as amended with a change in title and Policy H-310.912 reaffirmed.

Resolution 915 asks that our American Medical Association 1.) support educational initiatives to raise awareness about burnout, including but not limited to depression and suicide prevalence, among resident and fellow physicians; 2.) collaborate with the ACGME, COCA, and other interested parties to promote training for residency and fellowship programs on recognizing, screening, and intervening in cases of resident and fellow physician burnout; 3.) collaborate with the ACGME, COCA, and other interested parties to assist residency and fellowship programs in developing resident and fellow physician wellness initiatives; 4.) promote a culture of resident physician wellness within physician training programs; 5.) promote confidential and accessible mental health services for resident and fellow physicians; and 6.) encourage further research on the causal factors of resident and fellow physician burnout and its sequelae, including but not limited to its effect on quality of healthcare delivery and patient health outcomes.

Your Reference Committee heard testimony in support of Resolution 915 that emphasized the importance of physician wellness. Our AMA has extensive policy that promotes well-being among physicians in training; for this

reason, your Reference Committee recommends reaffirmation of existing policy in lieu of adoption of the first through the fourth and the sixth resolves. It was also noted that the intent of this resolution is consistent with the work being done by the Accreditation Council for Graduate Medical Education (ACGME) to support trainee well being as well as through the ACGME Clinical Learning Environment Review process. There was strong support for confidential, accessible, and affordable access to mental health services—hence the revised text in the fifth Resolve. Therefore your Reference Committee recommends that Resolution 915 be adopted as amended, and that Policy D-320.968 and H-310.912 be reaffirmed.

Policy recommended for reaffirmation:

D-310.968 Physician and Medical Student Burnout

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

H-310.912 Residents and Fellows' Bill of Rights

... (3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act....

(13) RESOLUTION 916 - PLASTIC MICROBEADS IN THE GREAT LAKES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 916 be amended by addition and deletion on lines 13-14 to read as follows:

RESOLVED, That our American Medical Association supports local, state, and federal laws ask Congress to banning the sale and manufacture of personal care products containing plastic microbeads in personal care products.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 916 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 916 be changed to read as follows:

BANNING PLASTIC MICROBEADS IN PERSONAL CARE PRODUCTS

HOD ACTION: Resolution 916 adopted as amended with a change in title.

Resolution 916 asks that our American Medical Association ask Congress to ban plastic microbeads.

Nearly all testimony supported this resolution. An estimated 8 trillion microbeads enter into aquatic habitats in the United States on a daily basis. These microbeads may mimic natural food supplies, attract pollutants, and concentrate contaminants along the food chain, thus having the potential to impact both marine ecosystems and human health. Some concern was expressed that peer-reviewed medical literature demonstrating harm from these substances is lacking. Additionally, some medical products may contain microbeads, so there was concern about the broad scope of the resolution. Nevertheless, based on the sheer expansion of their use, a number of states and municipalities have already enacted legislation to ban plastic microbeads in personal care products. In addition, federal legislation has been introduced. Given the availability of natural alternatives to plastic microbeads, your Reference Committee recommends this resolution be adopted as amended with a change in title to reflect that this is an issue beyond the Great Lakes, and should apply to personal care products.

(14) RESOLUTION 919 - CPR AND AED TRAINING AND EQUIPMENT FOR SCHOOLS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends Policy H-130.938 be amended by addition and deletion to read as follows:

H-130.938 Cardiopulmonary Resuscitation (CPR) and Defibrillators
 Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (67) endorses federal regulation and/or legislation increasing funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (78) supports the development and use of universal connectivity for all defibrillators; and (89) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-130.939 be adopted in lieu of Resolution 919.

HOD ACTION: Amended Policy H-130.939 adopted in lieu of Resolution 919.

Resolution 919 asks that our American Medical Association 1.) support the establishment of CPR and AED trained personnel and automatic external defibrillators on all grade K-12 school campuses and at all school events; 2.) support all grade K-12 schools in developing an emergency action plan for sudden cardiac events; 3.) support CPR and AED instruction for all high school students prior to graduation; and 4.) support legislation to fund CPR and AED material and training.

Considerable supportive testimony was offered, citing the prevalence of sudden cardiac events and the improved outcomes of people who are administered CPR and defibrillation. With the increased installation of AEDs in public places, it is important that the public is trained in how to administer CPR and use AEDs in emergencies. Of additional importance is the training of school personnel, and the establishment of an emergency plan for when cardiac events happen at schools or school events. Having these systems in place could reduce the incidence of

sudden death in athletes at school events. Some sentiment was expressed for deleting reference to AEDs in the 3rd resolve and deleting the 4th resolve in its entirety. Your Reference Committee notes that much of what is being asked in Resolution 919 is already part of AMA Policy H-130.939, and recommends amending that policy to include important points not already included, such as the installation of AEDs on school campuses, training of school personnel, and the development of an emergency action plan for sudden cardiac events that happen in school settings.

(15) RESOLUTION 922 - MARIJUANA POINT OF SALE WARNING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 922 be amended by addition and deletion on lines 22-24 to read as follows:

RESOLVED, That our American Medical Association advocate for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products at marijuana dispensaries regarding the potential dangers of marijuana use during pregnancy and breastfeeding wherever these products are sold or distributed.

RECOMMENDATION B:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 922 be changed.

CANNABIS WARNINGS FOR PREGNANT AND BREASTFEEDING WOMEN

HOD ACTION: Resolution 922 adopted as amended with a change in title.

Resolution 922 asks that our American Medical Association advocate for regulations requiring point-of-sale warnings at marijuana dispensaries regarding the potential dangers of marijuana use during pregnancy.

Testimony strongly supported the intent of this resolution. Some support also was offered to expand the target to include many other specific warnings, and the product label itself, for cannabis and cannabis-based products (eg, edibles). Concern was expressed that by specifying “dispensaries” other points of sale, such as legal distribution in Colorado, might not be included. While a number of states have requirements for health warnings on cannabis product labels, Oregon appears to be the only state that currently requires a point of sale warning at dispensaries regarding cannabis use in pregnant or breastfeeding women.

A number of states have cannabis product label requirements that include the health risks associated with consumption, but not all of these states include specific warnings for pregnant and breastfeeding women. Instead, many have a general warning about the potential for causing “harmful health effects” or impairment related to driving or operating heavy machinery. Your Reference Committee believes that keeping the focus of this resolution on pregnancy and breastfeeding is appropriate, and to include both point-of-sale and product label warnings is wise public policy.

(16) RESOLUTION 923 - MENTAL HEALTH CRISIS INTERVENTIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 923 be amended by addition and deletion on page 2, line 5 to read as follows:

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

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 923 be adopted as amended.

HOD ACTION: Resolution 923 adopted as amended.

Resolution 923 asks that our American Medical Association 1.) continue to support jail diversion and community based treatment options for mental illness; 2.) support implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; and 3.) explore federal funding to encourage increased community and law enforcement participation in crisis intervention training programs.

Testimony was heard in strong support of this resolution and noted the success of jail diversion and crisis intervention programs. Testimony suggested that the second Resolve statement include programs other than the Crisis Intervention Team (CIT) model, but as currently written, CIT programs are cited as one example. A suggestion was also heard to expand this resolution to include the juvenile population. The CSAPH is working on a report on the issue of juvenile justice reform for the 2016 Annual Meeting. Your Reference Committee recommends that the CSAPH report include this topic. Since Congress has provided grants to state and local governments for crisis intervention training through the Mentally Ill Offender Treatment and Crime Reduction Act since 2005, your Reference Committee recommends supporting rather than exploring federal funds for this purpose.

(17) **RESOLUTION 924 - ALTERNATIVE PATHWAYS TO BOARD RECERTIFICATION**

RESOLUTION 925 - NATIONAL BOARD OF PHYSICIANS AND SURGEONS' (NBPAS) RECERTIFICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 924 be deleted.

~~**RESOLVED**, That our AMA support alternative mechanisms for board recertification which are determined to be equivalent in quality to established recertification pathways.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 924 be adopted as amended in lieu of Resolution 925.

HOD ACTION: Resolutions 924and 925 referred for report back at A-16.

Resolution 924 asks that our American Medical Association 1.) review alternative pathways to board recertification that can assist physician credentialing and recredentialing by entities such as medical staffs, hospitals, employers and third party payers; and 2.) support alternative mechanisms for board recertification which are determined to be equivalent in quality to established recertification pathways.

Resolution 925 asks that our American Medical Association advocate for the National Board of Physicians and Surgeons to be recognized as an alternative to ABMS boards for recertification for physicians nationally.

Your Reference Committee heard mixed testimony that reflected differences of opinion on this complex item. Testimony supported lifelong learning and the need to keep current with advances in clinical practice, technology, and assessment. Our AMA has adopted extensive policy on maintenance of certification (MOC) that reinforces the need for ongoing learning and practice improvement and supports the principles of MOC. There was concern that the pathway to board recertification through the American Board of Medical Specialties (ABMS) and its specialty boards is costly and time consuming and diverts physicians from their focus on active patient care. In addition, there was also concern expressed about the lack of evidence to support the assertion that specialty organizations, such as the American College of Cardiology, had plans to develop alternative pathways to board recertification, as noted in lines 8 through 11 of the Resolution. The Council on Medical Education closely monitors the development and implementation of maintenance of certification standards and reports back to the HOD annually. Given the complexity of the issues presented, this item may benefit from a study of alternative mechanisms. Further, your Reference Committee believes that the study called for in the first Resolve of Resolution 924 should be completed before supporting alternative pathways to recertification, as called for in the second Resolve of Resolution 924 and Resolution 925. For these reasons, your Reference Committee recommends that only the first Resolve of Resolution 924 be adopted in lieu of Resolution 925.

(18) RESOLUTION 927 - SHOULD DRUG ADS BE BANNED?

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following Substitute Resolution 927 be adopted.

BAN DIRECT-TO-CONSUMER ADVERTISEMENTS OF PRESCRIPTION DRUGS AND IMPLANTABLE MEDICAL DEVICES

RESOLVED, that our American Medical Association support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

RESOLVED, that Policy H-105.988 be rescinded.

HOD ACTION: First Resolve of Substitute Resolution 927 adopted, second Resolve of Substitute Resolution referred for decision.

Resolution 927 asks that our American Medical Association convene a taskforce to study issues arising from direct-to-consumer (DTC) advertising of prescription drugs and implantable devices, including, but not limited to, whether DTC advertising is educational for patients as well as the effects of DTC advertising on the patient-physician relationship and healthcare utilization and costs.

Strong supportive testimony was offered on this resolution and many speakers agreed that it was time to revisit this issue. Others believed that sufficient research on the pros and cons of direct-to-consumer advertising (DTCA) already was available, and that convening a task force *per se* was unnecessary. The United States is only one of two countries in the world (New Zealand) that allows this practice. Ultimately, the goal of advertising is to drive choice and demand for a product, not educate, although some patients may be prompted to visit a physician based on increased awareness of a specific disease mentioned in DTCA. The intersection of DTCA with the cost of drugs is another factor. Testimony also suggested that it was appropriate to support a ban altogether. Your Reference Committee agrees.

Policy to be rescinded:

H-105.988 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices
 It is the policy of our AMA: 1. That our AMA considers acceptable only those product-specific DTC advertisements that satisfy the following guidelines: (a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device, and the disease, disorder, or

condition for which the drug or device is used. (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing. (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products. (d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended. (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable. (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient. (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition. (h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed. (i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement. (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved. (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines. 2. That our AMA opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines. 3. That the FDA review and pre-approve all DTC advertisements for prescription drug or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product. 4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTC. 5. That DTC advertisements for newly approved prescription drug or implantable medical device products not be run until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTC for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it. 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTC advertisements. 7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTC, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public. 8. That our AMA supports the concept that when companies engage in DTC, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine. 9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-specific DTC and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5.015 and to adhere to the ethical guidance provided in that Opinion. 10. That the Congress should request the Agency for Healthcare Research and Quality (AHRQ) to perform periodic evidence-based reviews of DTC in the United States to determine the impact of DTC on health outcomes and the public health. If DTC is found to have a negative impact on health outcomes and is detrimental to the public

health, the Congress should consider enacting legislation to increase DTC regulation or, if necessary, to prohibit DTC in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution. 11. That our AMA continues to monitor DTC, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTC, as necessary. 12. That our AMA supports “help-seeking” or “disease awareness” advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).

(19) RESOLUTION 901 - ACCESS TO MENTAL HEALTH CARE FOR MEDICAL TRAINEES

RESOLUTION 913 - MENTAL HEALTH SERVICES FOR MEDICAL STAFF

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 901 and 913 be referred.

HOD ACTION: Resolutions 901 and 913 referred.

Resolution 901 asks that our American Medical Association 1.) support the provision of on-campus mental health care in medical schools and residency programs that goes beyond supportive counseling; and 2.) encourage ongoing and future initiatives by medical schools and residency programs to provide urgent and emergent access for all medical trainees to psychiatrists that could include an in-house board-certified psychiatrist.

Resolution 913 asks that our American Medical Association encourage health systems, hospitals, and medical schools to offer physicians and medical students access to confidential and comprehensive mental health services not affiliated with their place of employment.

For both Resolution 901 and 913, your Reference Committee heard testimony that emphasized the importance of making confidential and comprehensive mental health services available to medical students, and resident and fellow physicians. It was noted that Liaison Committee on Medical Education (LCME) accreditation standards require medical schools to provide medical services at sites in reasonable proximity to the locations of their required educational experiences, and that the LCME collects data on access to psychiatric services and student satisfaction with mental health services. It was also noted that this item is consistent with the work being done by the Accreditation Council for Graduate Medical Education (ACGME) to support trainee well-being, through such efforts as the ACGME Clinical Learning Environment Review process. There was concern expressed during testimony about providing students and residents access to in-house psychiatrists for urgent and emergent care. It was noted that a psychiatrist located in reasonable proximity to training sites would be the most appropriate caregiver so that students and residents would not be obligated to receive care from a physician who is involved in their academic assessment and advancement. Other factors related to OSHA standards and occupational health care regulations also need to be considered, as well as the health of physicians beyond training years. Due to many factors that need to be addressed, your Reference Committee recommends referral of Resolutions 901 and 913.

(20) RESOLUTION 903 - MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 903 be referred.

HOD ACTION: Resolution 903 referred.

Resolution 903 asks that our American Medical Association oppose further requirements for physician board certification of physicians beyond the 10-year board recertification exams, placing on hold any additional

maintenance of certification requirements until objective study of the validity and cost-effectiveness of such additional requirements are complete.

Your Reference Committee heard mixed testimony on Resolution 903. There was concern that the cost and time commitment required to complete maintenance of certification (MOC) is placing an undue burden on physicians. Furthermore, there have been differences of opinion about the efficacy of MOC implementation in improving physician care and patient outcomes. The Council on Medical Education is actively engaged in discussion with various stakeholders including the American Board of Medical Specialties, to make meaningful and effective changes in the methodology of maintenance of professional competency. Some specialties have already implemented alternative methods of MOC, which meet the goals of this resolution. Adopting this resolution could hinder the Council's ongoing work to improve the options available for MOC. However, the Council understands the concerns that led to the genesis of the resolution and is committed to continuing the study of this issue. The Council is preparing a report for A-16 on this topic. Due to the complexities of the issues raised in the resolution and the need for additional study, your Reference Committee recommends referral of Resolution 903.

(21) **RESOLUTION 918 - PROMOTING THE SUCCESSFUL CLINICAL OUTCOME OF PRIMARY AMEBIC MENINGOENCEPHALITIS**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 918
not be adopted.

HOD ACTION: Resolution 918 not adopted.

Resolution 918 asks that our American Medical Association 1.) work with the Centers for Disease Control and Prevention on training and education relating to Primary Amebic Meningoencephalitis (PAM); 2.) support required national reporting of PAM; and 3.) support clinical guidelines and standards of care that promote rapid diagnosis and effective treatment of PAM.

Limited testimony was offered on Resolution 918. The sponsor noted the seriousness of this condition and the difficulty in diagnosing and treating it. Another person noted that it is rare (3-4 reported cases per year in the U.S.) and that not enough is known about it to require reporting, and/or develop evidence-based clinical guidelines for diagnosis and treatment. Your Reference Committee is aware that the Centers for Disease Control and Prevention has already developed extensive educational materials on *N. fowleri* infection and PAM, and that investigational drugs for the treatment of PAM are available directly from the CDC. Your Reference Committee recommends that Resolution 918 not be adopted.

(22) **RESOLUTION 917 - EQUITY IN GRADUATE MEDICAL EDUCATION FUNDING**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-310.916
be reaffirmed in lieu of Resolution 917.

HOD ACTION: Resolution 917 adopted.

Resolution 917 asks that our American Medical Association strongly advocate that: 1. there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions, and 2. there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

Testimony was strongly supportive of the need to improve funding for graduate medical education (GME). AMA policy clearly calls for advocacy for adequate and stable GME funding. Some noted that making comparisons of the importance of training physicians vs. other health care professionals could exacerbate intra-professional tensions with podiatry, nursing, and other fields. Your Reference Committee believes that current AMA policy covers the

intent of the resolution. Policy H-310.916 states that our AMA “will insist that any new GME funding to support GME positions be available only to ACGME and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.” Therefore, your Reference Committee recommends that Policy H-310.916 be reaffirmed in lieu of Resolution 917.

Policy recommended for reaffirmation:

H-310.916 Funding to Support Training of the Health Care Workforce

Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.