

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

71st INTERIM MEETING

Honolulu, Hawaii

November 11–13, 2017

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 71st Interim Annual Meeting at 2 p.m. on Saturday, Nov. 11, in the Kalakaua Ballroom at the Hawaii Convention Center in Honolulu, Hawaii, Susan R. Bailey, MD, Speaker of the House of Delegates, presiding. The Sunday, Nov. 12 and Monday, Nov. 13 sessions also convened in the Kalakaua Ballroom. The meeting adjourned following the Monday afternoon session.

INVOCATION: The following invocation was delivered by Chaplain Lt Col David W. Kelley, Deputy Command Chaplain for Pacific Air Forces. He has served in uniform for over 30 years, both in the United States Air Force and Army. He is a Southern Baptist Convention endorsed chaplain.

Lord, today your blessings over us are bountiful and rich. Although this world often seems dark, we have many things to be thankful for. We thank you for life, joy, love, family, purpose, laughter, comradery, those who choose to strive alongside us, and for those who have committed their lives to helping others. Lord, I thank you for healers such as those gathered here today. I believe you have a special place in your heart for those who seek the wellness of others, those who toil to alleviate suffering, those who look into the eyes of a child stricken with cancer and provide hope. Thank you for those who meet people on the worst day of their lives, and deliver precious healing salve. Today, in this meeting, I ask you to give these delegates what they give to others—knowledge to overcome, faith to believe when times are desperate, calm in the midst of chaos, and strength to persevere when they are weary.

Lastly, on Veteran's Day and as the odds are, I pray a special prayer for that one physician administering care in a dusty operating room on a distant battlefield to one of our nation's sons and daughters touched by war. Steady his hand, calm her heart, guide the knife, use that doctor to mend that which man has broken, and let that healer know that he is not forgotten. Let her know she is a national treasure.

Lord, thank you to those, and their families, who sacrifice so much, so that others may live. In your name I pray. Amen.

AWARD PRESENTATIONS: The following awards were presented during the opening session on Saturday, Nov. 11.

- Distinguished Service Award – Boris D. Lushniak, MD, received the Distinguished Service Award for meritorious service in the science and art of medicine.
- Medal of Valor – Robert Smith, MD, received the Medal of Valor for his work during the civil rights movement in Mississippi, when he provided health care to those with little or no access.

Medical Executive Lifetime Achievement Awards were presented to:

- Karen L. Hackett, the recently retired executive vice president of the American Academy of Orthopaedic Surgeons.
- Christine Ignaszak-Nadolny, executive director of the Medical Society of the County of Erie, in New York.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Michael B. Hoover, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, Nov. 11, 482 out of 556 delegates (86.7%) had been accredited, thus constituting a quorum; on Sunday, Nov. 12, 516 delegates (92.8%) were present; and on Monday, Nov. 13, 532 (95.7%) were present.

RULES REPORT - Saturday, November 11**HOUSE ACTION: ADOPTED**

Madam Speaker, Members of the House of Delegates, your Committee on Rules and Credentials recommends that:

1. **House Security**
Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly badged will be permitted to attend.
2. **Credentials**
The registration record of the Committee on Rules and Credentials shall constitute the official roll call at each meeting of the House.
3. **Order of Business**
The order of business as published in the Handbook shall be the official order of business for all sessions of the House of Delegates. This may be varied by the Speaker if, in her judgment, it will expedite the business of the House, subject to any objection sustained by the House.
4. **Privilege of the Floor**
The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.
5. **Procedures of the House of Delegates**
The November 2017 edition of the “House of Delegates Reference Manual: Procedures, Policies and Practices” shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates.
6. **Limitation on Debate**
There will be a 3-minute limitation on debate per presentation subject to waiver by the Speaker for just cause.
7. **Conflict of Interest**
Members of the House of Delegates who have a substantial financial interest in a commercial enterprise, which interest will be materially affected by a matter before the House of Delegates, must publicly disclose that interest before testifying at a reference committee on the matter or speaking on the floor of the House of Delegates on the matter.
8. **Conduct of Business by the House of Delegates**
Each member of the House of Delegates, and the AMA Officers and Board of Trustees resolutely affirm a commitment to be courteous, respectful and collegial in the conduct of House of Delegate actions, characteristics which should exemplify the members of our respected and learned profession.
9. **Respectful Behavior**
Courteous and respectful dealings in all interactions with others, including delegates, AMA and Federation staff, and other parties, are expected of all attendees at House of Delegates meetings, including social events apart from House of Delegates meetings themselves. Hugs and embraces, while not always inappropriate, are not universally accepted. Meeting attendees are reminded of their personal responsibility, while greeting others, to consider how the recipient of their greeting is likely to interpret it. Instances of unwelcome or inappropriate behavior should be brought to the attention of the Speakers.

SUPPLEMENTARY REPORT – Sunday, November 12**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**

**LATE RESOLUTIONS 1002 (234), 1003 (235), 1004 (236) and 1005 (237) ACCEPTED
LATE RESOLUTION 1001 NOT ACCEPTED
EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 210, 219, 221
228, 804, 807, 815 and 821**

LATE RESOLUTIONS

The Committee on Rules and Credentials met Saturday, November 11, to discuss late resolutions. Sponsors of late resolutions are informed of the time the Committee on Rules and Credentials meets to consider late resolutions, 8:30 a.m. on Saturday, and are given the opportunity to present for the Committee's consideration the reasons the resolutions could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting. Sponsors of late resolutions 1001-1005 appeared to discuss their resolutions.

Recommended for acceptance:

Late 1002 - Health Insurance Company Purchase by Pharmacy Chains
Late 1003 - AMA Advocacy Efforts for Emergency Medicaid Funding and Assistance - Puerto Rico
Late 1004 - Preserving Tax Deductibility of Student Loan Interest Payments and High Medical Expenses
Late 1005 - Implementation of Score Assessment for Cost Under MACRA MIPS

Recommended not be accepted:

Late 1001 - Reaffirmation of AMA Policy on the Use of Unlicensed Personnel to Perform Surgery, with Attention to Hair Restoration Surgery

REAFFIRMATION RESOLUTIONS

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

Resolution 210 - MIPS and Small Practices
Resolution 219 - Certified EMR Companies Practices of Charging Fees for Regulatory Compliance
Resolution 221 - House of Representatives Bill HR 2077, Restoring Patient's Voice Act
Resolution 228 - Drug Discount Cards
Resolution 804 - Prior Authorization
Resolution 807 - Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals
Resolution 815 - Pediatric Representation for E/M Documentation Guideline Revision
Resolution 821 - Hormonal Contraception as a Preventive Service

APPENDIX

- Resolution 210 – MIPS and Small Practices
 - D-390.949, Preserving Patient Access to Small Practices Under MACRA
 - H-390.838, MIPS and MACRA Exemption
 - The AMA already has policy that asks the AMA to advocate for an exemption from MIPS and MACRA for small practices. The AMA has continually advocated for an exemption for small practices, and reduced reporting requirements for small practices under MIPS. In addition, in the 2018 Quality Payment Program proposed rule, the Centers for Medicare and Medicaid Services increased the low volume threshold to exclude all physicians with less than or equal to \$90,000 in Medicare Part B allowed charges, or that provide care for 200 or fewer Part B-

- enrolled Medicare beneficiaries. This exclusion will ensure a large number of small practices do not have to participate in the Quality Payment Program in 2018.
- Resolution 219 – Certified EMR Companies Practices of Charging Fees for Regulatory Compliance
 - D-478.975, Maintenance Payments for Electronic Health Records
 - D-478.996, Information Technology Standards and Costs
 - Resolution 221 – House of Representatives Bill HR 2077, Restoring Patient's Voice Act
 - H-320.948, Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans
 - H-320.968, Approaches to Increase Payer Accountability
 - H-320.958, Emerging Trends in Utilization Management
 - H-320.952, External Grievance Review Procedures
 - In addition, AMA has advocated strongly for utilization management to be non-intrusive, to reduce administrative burdens, and to allow for adequate input by the medical profession. Furthermore, existing policy requires that review entities respond within 48 hours to patient or physician requests for prior authorization and expedited review mechanism should be created for urgent medical conditions. In fact, AMA used this policy to write a letter of support in May 2017 for the Restoring the Patient's Voice Act of 2017 (H.R. 2077), which is the reason for this resolution. AMA also released Prior Authorization Principles (which was supported by over 100 stakeholder groups) that already cover the salient points of the resolution.
 - Resolution 228 – Drug Discount Cards
 - H-125.977, Non-Formulary Medication and the Medicare Part D Coverage Gap
 - Please note that due to the Affordable Care Act, the doughnut hole will close in 2020 and it is unlikely that legislation would pass and be implemented before 2020 since the 2020 cost year call for bids will go out in early 2019.
 - Resolution 804 – Prior Authorization
 - H-320.939, Prior Authorization and Utilization Management Reform
 - H-320.950, Eliminating Precertification
 - H-320.945, Abuse of Preauthorization Procedures
 - H-185.942, Third Party Payer Quantity Limits
 - H-320.982, Payer Accountability
 - H-320.968, Approaches to Increase Payer Accountability
 - D-320.993, Insurance Coverage Appeals
 - D-190.974, Administrative Simplification in the Physician Practice
 - In addition, the AMA has been very active in advocating for a reduction in both the number of physicians subjected to prior authorization (PA) and the overall volume of PA. The AMA convened a workgroup of state and specialty medical societies, national provider associations and patient representatives to create a set of best practices related to prior authorization and other utilization management requirements. The workgroup identified the most common provider and patient complaints associated with utilization management programs and developed the attached Prior Authorization and Utilization Management Reform Principles, which address the intent of Resolution 804. The principles have gained widespread support since their release, with over 100 stakeholder organizations signing on in support of their objectives. The AMA also fielded a quantitative physician survey on PA in 2016. The AMA Council on Medical Service has been very active on this issue as well, having presented Council on Medical Service Report 8-A-17, "Prior Authorization and Utilization Management Reform," and Council on Medical Service Report 7-A-16, "Prior Authorization Simplification and Standardization."
 - Resolution 807 – Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals
 - D-160.923, Urge AMA to Release a White Paper on ACOs
 - H-160.915, Accountable Care Organization Principles
 - H-285.954, Physician Decision-Making in Health Care Systems
 - D-240.994, Payment Variations Across Outpatient Sites of Service
 - H-330.925, Appropriate Payment Level Differences by Place and Type of Service
 - D-330.997, Appropriate Payment Level Differences by Place and Type of Service
 - H-450.938, Value-Based Decision-Making in the Health Care System
 - In addition, the AMA's recent Outpatient Prospective Payment System (OPPS) comments asked for neutral payment policy between ambulatory surgical centers and hospital outpatient departments. That AMA letter further stated that CMS is limited in adopting a payment policy to address differentials in payment between Medicare inpatient and outpatient facilities by statutory provisions and distinguishes between the Inpatient Prospective Payment System (IPPS) and OPPS as fundamentally different payment systems with one making a single payment for all services the hospital provides and the other making multiple payments depending on the services provided. Moreover, the AMA commented that payment under IPPS should be higher as it is paying for room and board, which are not costs that are expected to be incurred by hospitals under OPPS.

- Resolution 815 – Pediatric Representation for E/M Documentation Guideline Revision
 - H-70.973, AMA CPT Editorial Panel and Process
- Resolution 821 – Hormonal Contraception as a Preventive Service
 - H-180.958, Coverage of Prescription Contraceptives by Insurance
 - H-425.969, Support for Access to Preventive and Reproductive Health Services

CLOSING REPORT – Monday, November 13

HOUSE ACTION: ADOPTED

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

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

Whereas, The Interim Meeting of the House of Delegates of the American Medical Association has been convened in Honolulu, Hawaii, during the period of November 11-13, 2017; and

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

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

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

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

APPROVAL OF MINUTES: The Proceedings of the 166th Annual Meeting of the House of Delegates, held in Chicago, Illinois, June 11–15, 2017, were approved.

ADDRESS OF THE PRESIDENT: AMA President David O. Barbe, MD, delivered the following address to the House of Delegates on Saturday, Nov 11.

Madam Speaker, officers, delegates, physician colleagues, honored guests:

I appreciate the opportunity to address you again today as your president. Before I begin, I, too, would like to thank all of our active duty military members, veterans, and their spouses and other family members who are with us today. Thank you for your service!

At our Annual Meeting in June, you may recall, I talked about physician leadership. I talked about how we are all leaders in a variety of contexts: in our practices, in our communities, and as members of organized medicine. Our patients, our colleagues and our communities look to us for leadership. And I challenged all of us to ask ourselves, continually: What kind of individual leaders will we be?

Now, I'd like to take that concept a bit further and talk about what it takes to put together the team that wins. What is the formula for a winning team?

- A formula that keeps soldiers committed to each other and to their mission, even under enemy fire.
- A formula that propels companies to the top of their field and keeps them there: think Apple, Nike, Amazon.
- A formula that sustains winning sports teams.

Winning teams recognize that the greatest success comes not from the effort of one or more individuals but from a team effort. One of the greatest individual talents in baseball, George Herman “Babe” Ruth put it this way, “The way a team plays as a whole determines its success. You may have the greatest bunch of individual stars in the world, but if they don’t play together, the club won’t be worth a dime.”

Every member of the House of Delegates is a physician leader and each committed to our “group mission” of promoting the art and science of medicine and the betterment of public health. However, our success will be determined by how well we play or work together, as a team, to achieve our common goals. I submit to you it is that shared purpose, that common vision, and our willingness to work together to fight aggressively for it, that moves medicine forward. So, the team that wins shares a common vision, and works aggressively to achieve it.

The AMA has worked relentlessly to WIN, not only for our members, but for all physicians and for patients, achieving a direct, positive impact as we move medicine forward.

When physicians ask, “What has AMA done for me lately?” which they often do, I tell them, “plenty.” It’s almost hard to know where to start.

The AMA fought back against insurance mergers that would have decreased competition, weakened our negotiating power, and the Anthem-Cigna merger alone, would have cost physicians an estimated \$500 million dollars in reduced payments every year. And we won.

Some of our most significant wins have come through our advocacy on behalf of physicians as we transition to a new Medicare payment system, the MACRA-Quality Payment Program. We fought for a simple way for physicians to avoid a four percent payment cut in 2019 and won. Physicians can avoid penalties by simply reporting one quality measure for one patient this year. If you have not already taken steps to avoid a penalty, be sure you take advantage of this option before the end of 2017.

We fought for—and won—retroactive policy changes to align Medicare’s old reporting programs with the new MIPS program, helping doctors avoid millions of dollars in penalties under prior law.

In the 2018 MACRA rule released just last week we fought for greater flexibility for small physician practices, and we won, with special scoring rules, hardship exemptions, bonus points and other provisions to level the playing field with larger practices.

And, we successfully fought to postpone a mandate for physicians to upgrade their EHRs.

We are working to make sure every physician—in every practice setting and every specialty—is prepared to make the successful transition to the MACRA-QPP, and we’ve posted multiple resources on our website including: tools, tutorials, podcasts and education modules.

The AMA continues to fight against burdens imposed by government and private insurers and we are winning: We fought to allow physicians to refuse virtual credit card payments from insurers, because they carry fees that reduce our reimbursements and we won. We are fighting to reform the prior authorization process, and starting to see results; some insurers are beginning to reduce or eliminate their prior authorization requirements. We are fighting to prevent IT vendors from blocking information or making it expensive for physicians to share data and we are making progress. We are fighting physician burnout and the time crunch by working to improve EHRs, mobile devices, and interoperability, and again, those efforts are showing signs of success. Our work to improve physician satisfaction by reducing these headaches and making the practice environment more satisfying is at the heart of the AMA’s shared strategic vision, as we: provide practice and payment resources; foster lifelong professional development, and improve the health of the nation.

Colleagues, these are major wins for our profession! This is the value of the AMA.

In addition, we are fighting high drug prices through our Truth in Rx campaign. More than 150,000 people have signed our online petition calling for increased drug pricing transparency. We are encouraged to see Members of Congress now also calling for transparency.

We continue to fight the great public health crisis of our time: opioid misuse and addiction. We have not won this battle yet, but we are making progress. Opioid prescribing is decreasing in every state, and physicians are becoming better educated and better prepared to assist their patients with pain management and addiction. The opioid crisis is a public health emergency and everyone—from state and federal government officials, to insurers, to physicians and others—everyone has a role to play in reversing it. Physicians must continue to lead in their own practices and advocate for more resources, more treatment options and coverage for those alternatives, better access to multi-modal pain care, and to combat the stigma that often prevents patients from seeking treatment.

As you can see, we are not only advocating aggressively for physicians, we are advocating aggressively for patients. Nowhere is this more evident than in the renewed debate over health system reform.

From the beginning, we have fought for nine key principles, including affordability, accessibility, protecting safety net programs and patient protections, with one overarching goal: maintaining and expanding health care coverage for Americans. Throughout this debate, the AMA has been a voice of reason, asking Congress to put Patients Before Politics, and urging Congress to work on bipartisan, sustainable solutions. We have worked with other well-respected advocacy organizations representing patients, hospitals, and the AARP, to magnify our collective voice to maintain coverage, patient protections and safety net programs.

In fact, the AMA has been the leading voice among non-partisan organizations in this debate. Listen to this: an analysis showed that we achieved a 48 percent “share of voice” in the media for leading the national conversation. That is more than AARP, the American Hospital Association and the insurance industry lobby (AHIP) combined.

So far, leadership from the AMA and like-minded groups has kept Congress away from the edge of the cliff. We have kept them from passing proposals that would eliminate coverage for millions of Americans. And in addition: the Medicaid safety net and patient protections have also been preserved. Sometimes, for winning teams, it’s all about the defense.

And, while it’s impossible to predict where the debate will go from here, our steadfast commitment to putting patients before politics and our unwillingness to be drawn into the partisan quagmire will continue to reassure the public that the AMA, as the House of Medicine, is a voice of reason in Washington.

The team that wins also creates partnerships that make us stronger. Along with our advocacy partnerships, the AMA is working with outside organizations to strengthen and increase the momentum behind our top initiatives. Those partnerships are exponentially increasing the reach of the AMA and our ability to solve health care challenges.

Similarly, we know the AMA alone, cannot solve the burden of chronic disease that affects half of American adults and consumes more than 75 percent of the \$3 trillion dollars per year in health care spending. But, working with partners like the Centers for Disease Control and Prevention, the American Diabetes Association, and the American Heart Association, we can have a meaningful impact.

- Nearly half a million people have completed our online prediabetes test at DoIHavePrediabetes.org;
- We are also pleased to report more insurers are moving to cover the proven Diabetes Prevention Program;
- Medicare has announced it will begin covering the Diabetes Prevention Program for seniors beginning next spring; and
- Just this week, the AMA announced an expansion of our statewide prevention efforts -- to eight more states – in an effort to reach more of the 84 million American adults with prediabetes – most of whom don’t even know they have it.

AMA’s prediabetes campaign has been so successful that the Improving Health Outcomes team is again working with the Ad Council and the American Heart Association on another public awareness campaign, this time focusing on hypertension. This new campaign targets adults who have been diagnosed with high blood pressure but are not adequately controlled. In fact, I’ll be stopping in Los Angeles on the way back from this meeting to do a series of media interviews about this campaign. If, working in partnership with patients and outside organizations, we can

slow the progress of these chronic diseases or prevent them altogether, that will be a significant victory for public health. It will mean a much brighter future for our patients.

Dr. Madara will discuss our efforts to create an Innovation Ecosystem for the profession. This includes partnerships with organizations, venture capitalists and tech developers that are bringing the physician perspective to the development of new health technologies. And, I can tell you from my recent experiences speaking at the Samsung Developers Conference and at the Connected Health Conference, these industries are very eager to partner with physicians to make these products better.

As you will hear, exciting projects are underway that will transform patient care and the physician workflow, projects that would not be possible without our outside partners.

Which brings me to my next point. The team that wins prepares for the future. Here at the AMA, we are not just concerned about our patients and our professional lives. We are working hard to be sure the physicians of the future are prepared to care for the patients of the future.

Our Accelerating Change in Medical Education (ACE) Initiative has made amazing progress just in the four years since its creation. From recognizing that the curriculum needed to be modernized to the implementation of promising innovations in our thirty-two ACE Consortium schools, to the spread of these innovations to dozens of other schools, we are succeeding in our original goal of Changing Medical Education.

Among the most promising developments: schools are not just focusing on helping students become excellent clinicians, they are helping them understand the health system and training them to become physician leaders and innovators. In fact, an increasing number of medical schools across the country have now incorporated the AMA's health systems science textbook into curricula. Future physicians will be called on to lead the way in solving countless health care challenges. Thanks to the ACE initiative, they will have the skills they need to do that.

Teams that win also prepare for the future by understanding they need to mentor and encourage younger colleagues. In sports, we might call this "developing the farm team" or simply, "recruitment." In recent years, the AMA has made a concerted effort to recruit medical students to membership.

This has been a win-win, not just because students are joining, but because of the enthusiasm and commitment they are bringing with them. They are helping to shape a new, vibrant, forward-looking AMA, certainly no longer "your grandfather's AMA." Maybe not even your father's—or your mother's—AMA.

Medical students are asserting their perspectives and it's having a strong impact on policy. At our Annual Meeting in June, several resolutions passed the House that originated in the Medical Student Section. Among the concerns they have made sure we address: protecting immigrants and DACA-status individuals; simplifying and improving the USMLE exam; and addressing the serious problem of burnout, depression and suicide among students and residents. These medical students who are so enthusiastic about policy will one day carry the torch for this organization, and with our continued mentoring, I am confident the AMA will be in good hands.

And residents, we know you also feel pressure and stress like never before as you start your careers in medicine. I encourage you to stay with us as you make the transition into practice and stay active. We need you and, in turn, have much to offer you!

So, we've talked about the importance of preparing for the future, partnerships to make the team stronger; and commitment to shared goals and working aggressively to achieve those goals. There is, however, one more ingredient for a winning team: enthusiastic fans.

In the past few minutes I've described just a few of the AMA's recent wins on behalf of physicians and patients. Together we are moving medicine forward. In the past few months, I've had the opportunity to interact with our colleagues across the country to update them on all the AMA is doing. In every instance the response has been extremely positive. Members are encouraged, and many non-members tell me they are going to join based on what the AMA is doing for them and for their patients. We need to get our message out so more will know and will join us.

I opened with a quote by Babe Ruth on the importance of working together as a team. He made another observation that I think is equally important: “It’s hard to beat a person who never gives up.” Your AMA leadership will never give up in our efforts to advance our policies, achieve our common goals, and get our message out. However, as AMA leaders, we can only reach so many physicians. That’s why we need your help to get the message out. Fans attract new fans, so there is a huge multiplier effect when each of us reaches out to physicians in our own circle.

Just outside this ballroom, at the AMA membership booth you will find this brochure, which includes 13 examples of what the AMA has to offer physicians. These are the kinds of proof points I challenge each of you to share with your colleagues. Help them understand the value of today’s AMA. We know that Membership Moves Medicine. Let’s help our colleagues become part of our winning team, part of our AMA.

Thank you.

REPORT OF THE EXECUTIVE VICE PRESIDENT: The following report was presented by James L. Madara, MD, Executive Vice President of the American Medical Association, on Saturday, Nov. 11.

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

For more than 170 years the American Medical Association has been at the forefront of medicine. From creating the first code of medical ethics and establishing the professional standard to creating the coding backbone for tracking medical procedures. From sweeping public health campaigns that sought to end smoking to creating the medical school of the future and building partnerships with other leading institutions, such as the CDC and the American Heart Association, aimed at diabetes prevention and blood pressure control.

Such proof points show how the history of the AMA is intertwined with the history of American medicine. In 2012, it was exciting to describe our “moon shots”; our comprehensive plan to transform medicine around three strategic priorities—improving health outcomes, creating thriving physician practices, and creating the medical school of the future. I’ll update our many successes across these domains at the Annual Meeting next June.

Dr. Barbe outlined how the AMA advocates on behalf of patients and physicians, using our policy portfolio to shape legislative and regulatory decisions. Our voice is a mitigating force for national chaos that we seem to tilt toward as of late. The AMA’s critical work to stem the waterfall of disturbing legislative health care proposals rightly occupied much of our time and effort; and was lauded from many quarters for being principled (which by the way, it was). It exemplified strong leadership in medicine.

But I’d like to pivot a bit and use my time today to focus on the longer time-line; on problems that are fundamentally important, but less apparent in the daily headlines. I know you’re all familiar with Google Earth and its use on your smartphone or iPad. It’s fun to find where we live, then zoom out to our neighborhood, city, state, country, and finally, see our place in the world, to go from the granular to the broadest view possible.

I see some of you are on your smartphones now. You must be figuring out where I’m headed. That’s great. Thanks for following.

So, let’s zoom out for a moment to examine the long game. There are long-term needs that must be addressed regardless of what specific future health system architecture we find ourselves in. For example: We all know that clinical data sets need to be better organized for physicians, and that electronic health records have to assist us in better organizing what we need. We have a pressing need for interoperability, and interoperability defined by being able to transfer clinical meaning, and meaningful data objects, not just clinical data elements. Currently, we confront oceans of data, but only puddles of clinical meaning.

And even if our data were better organized to be more meaningful, we lack the appropriate utility for the secure and timely flow of data—what experts refer to as “clinical data liquidity.” Here’s the problem: You see a new patient who may have hypertension. His blood pressure is elevated, but is this real or a white-coat effect? Or the fact that he ran across the parking lot from Starbucks?

Luckily, during the visit, given the fluid current state of interoperability, you're able to effortlessly capture his blood pressure readings in digital form from another institution. I'm just joking. You can't do that. What's available to you isn't conclusive, and although he's been following his blood pressure at home, none of those data are connected to and embedded in an electronic record in any organized way. Instead, he scribbled his recordings down on paper somewhere, and recalls the "top" number always being about 125 or, on second thought, maybe it was 155; his handwriting's not that good. You bounce around the electronic record, history here, renal function there, searching for puddles of meaning. So, what's the AMA doing to address these needs? Needs that become more urgent as the number of data elements grow?

Our work at the AMA over the last four years on hypertension has led to a greater understanding of the complexity in evaluating this condition. For example, hypertension alone requires roughly 75 data elements to provide a complete picture of a patient's state with regard to this diagnosis. However, these data elements are scattered throughout the electronic record. Shockingly, a significant percentage of these vital data elements cannot be consistently captured at the level we need. Self-measured blood pressure readings that automatically connect to and become organized in the record being just one such example.

Data is so critical to a physician's understanding of a patient's health, and when elements take time to track down or are missing, it's like the fable of the blind men touching the elephant. One feels the trunk. Another the tail. One the ear. And each one of the men has in his mind a completely different image. That's what health care data are today, each of us touching data, bit-by-bit, then spending time conceptualizing the elephant.

For everyone else we are living in the Information Age, and yet even for that small pool of digital devices that have been well characterized as validated, evidence-based, and actionable, even the best are largely not connected. And the data that's ultimately entered into the record tends to not be organized in any useful way to say the least. Instead, you're in that ocean of disconnected data points that seem to lack context or organization, that is, to lack true meaning. And your EHR isn't going to help you much; you're on your own. Go in there and find those puddles.

This is an obvious pain point for physicians and it's why the AMA has launched the Integrated Health Model Initiative, IHMI for short, an endeavor to create a common data model throughout health care that is unlike anything that exists today. Our allies in the field are calling our IHMI solution both dearly needed and incredibly bold. It certainly could be a game-changer in health care delivery. IHMI can be accessed by any provider, group or organization, expert groups that propose data element models that then move toward conceptual solutions, that is, assembling elements for meaning.

Delivering on this promise will not be easy. It won't be quick. But physicians aren't the type to shy away from such challenges, especially when the potential is so great to transform our practices. We launched IHMI last month following two years of intensive work inside the AMA. And we're delighted that those from various sectors who've already joined us have expressed excitement for the project as well. These collaborators include IBM Watson, Intermountain Healthcare, Cerner, and the American Heart Association.

This initiative fills several other needs. Not only filling existing gaps, but also serving as a platform that will be patient-centric, capturing patient goals, for example. It seeks to assemble data elements into meaningful conceptualization of the patient's state.

It's been said that data is the oil of this century and so harnessing the power of health data in a way that is both efficient for the physician and improves patient care is an enormous and important challenge, one that should be led by physicians. And the result has to be a data solution that is easy and useful for physicians. IHMI seeks to accomplish this in three ways:

Number one: it will deliver better-organized and more relevant information about a patient's clinical data, including social determinants, and patient goals, into the hands of physicians at the point of care. It will provide meaning and context, not just data. Though all the data will be accessible, it will simply be better organized so the elephant is obvious.

Number two: it will create collaborative digital communities to identify costly clinical burdens and identify solutions through a neutral, physician-led validation process. Our own internal work will, as you would guess, have some focus on prediabetes and hypertension.

And number three: IHMI establishes a common data model that can be more easily shared across health systems, allowing the data elements of one vendor platform to be meaningfully translated to another. This achieves interoperability not simply by being able to share limited data elements, but by the ability to transfer real clinical meaning.

You can learn more about IHMI on our website. IHMI is one critical node in our innovation ecosystem. There are several others now as well, but I'll keep this mercifully brief and I'll highlight just one more. I selected it because, as I foreshadowed earlier, it deals with data as does IHMI.

The ambitious Innovation Lab we helped launch in Silicon Valley, Health2047, now has two years of solid work behind it. If we are successful through IHMI in organizing clinically meaningful data in ways—tailored to help physicians and provide conceptual meaning—and, can create interoperability for meaningful data, then we need what experts call “a data liquidity system,” an inexpensive pipeline for data flow. You might think of it as health care's utility for data transport.

This is exactly the thinking that created this Health2047 project and, with some early developmental success, it has just spun-off as a separate company. The project currently goes by the code name “SWITCH.” The transformational promise of SWITCH had sufficient gravitational pull to attract senior leaders and engineers from companies such as GE and Intel. SWITCH is a subscriber network that enables secure permissions-based sharing of health data among patients, physicians, payers and others in health care and technology. It will have the capacity to serve as an inexpensive utility for data movement in health care, not unlike our cities' power grids or underground water supply.

Another way to think about SWITCH is that it will bring to our health care sector what the currency utility called SWIFT has done for the financial sector. SWIFT is a platform for a permissions-based, secure transfer of currency and other financial data. The beauty of both IHMI and SWITCH is that either could be transformative alone, but together one can only imagine the impact! These tools will be in further development over the next two to four years.

As I said in the beginning, the AMA has many “immediate” projects; physician needs are very acute. The crafting of legislation, emerging regulatory frameworks, eliminating some of the common frustrations that contribute to physician burnout, these are NOW problems. But while we do this important and urgent work, we simultaneously need to keep our eye on the future by taking on some of the biggest and most difficult problems we know physicians will face. Our immediate impact work—our NOW work—as well as our work looking to the future, share a common, high-level goal: to extract physicians from a good chunk of the mind-numbing administrative and data entry chores you face and shift that currently misused time to what we trained for, time with our patients.

I've noticed something wonderful over the last few years in strategic discussions with many leaders in different health care sectors. Over and over I heard that real solutions need a trusted and neutral player at the center if transformative change is going to occur. It needs a natural convener of ideas and objectives. That's us. We're “Switzerland.” But more than that, these leaders of other sectors are beginning to appreciate that the truth of health care is to be found starting at the patient-physician interface, not at the administrative level.

As one industry leader put it to me, “physicians are the knowledge force in the field but everyone tries to manage around them, and that's where we get off track.” His point was that physicians need to seize a more central role in crafting health care. That's why the work in the AMA Innovation ecosystem, such as IHMI and SWITCH, starts by flipping the standard model of development. It starts at the patient-physician level, getting it right there first before it moves to administrative and other systems requirements. Flipping the model.

We need to flip the model because physicians ARE the knowledge force in health care. We ARE the ones leading entrepreneurs and industry to the pain points in health care. We ARE the ones responsible for creating a system that continuously promotes the art and science of medicine and the betterment of public health. And to get there, we just had to zoom out a bit.

Thank you.

COMMENTS FROM THE CHAIR OF THE AMPAC BOARD: The following comments were offered by Vidya Kora, MD, on Saturday, Nov. 11.

Madam Speaker and Mr. Vice Speaker, friends in the House of Delegates,

Good afternoon and aloha. I'm very happy to have this opportunity to address you as the chair of the AMPAC Board. Your continued support and active participation is vital to ensure that medicine has a place at the table when it comes to policymaking decisions in Washington, D.C.

Looking back at 2016 for just a moment, we did some great things. AMPAC contributed close to \$2 million to medicine-friendly candidates running for the United States House and Senate, 91% of whom won their races. We can see that that investment that we made is yielding real dividends today as we actively work Congress to make important changes to MACRA and hold the line on coverage protections for millions of Americans.

Looking ahead to 2018 and beyond, we must be mindful of our shared responsibility to remain active supporters and encourage our colleagues to do likewise. Right now this House's participation in AMPAC stands at 77%. That's good, but frankly it's not good enough. Our goal is to get to 100%. Our fights over things like MACRA, things like health system reform and other critical issues are far from over. Politicians in Washington look to leaders in the healthcare arena to help guide them. You can bet the pharmaceutical companies will be there. The health plans will be there. Hospitals will be there. What about us, the physicians?

AMPAC is your political voice in Washington, but we are only as strong as you make us. There is no excuse for anyone who is a member of this House of Delegates not to support AMPAC. Those who wish to distinguish themselves as true leaders of medicine, please participate in AMPAC at the Capitol Club level, either at silver, gold or platinum. Many of you have supported AMPAC at one of these levels for many years, and for that I am very grateful. Thank you very much, and I encourage you to keep that commitment up. For those that haven't, please come and visit us at the AMPAC booth just outside this hall. We are always friendly, but in these beautiful surroundings we are even friendlier, so please come and visit us.

Every year AMPAC holds drawing for Capitol Club members. This year's Festival of Fall sweepstakes is a four day, three night stay at the Twin Farms Resort, which is located in Barnard, Vermont, and I'm happy to announce this year's lucky winner: Dr. Andrew Ondo, a dermatologist from Las Cruces, New Mexico. Congratulations to Dr. Ondo. And thank you for your support to AMPAC's Capitol Club.

In closing, there's a concept in the Hawaiian culture akin to family, called Ohana. It is extremely important to the Hawaiian people, as it binds finds them together and creates a sense of shared commitment and responsibility to one another. They recognize it as a quality that collectively makes them stronger. And I would suggest to all of you that as physicians we can learn from the Hawaiians and embrace this period of Ohana while we are here in Honolulu. Republican or Democrat, no matter where we practice and regardless of our specialty, we are a family striving to provide the best possible care to all our patients. Let that be the unifying principle that guides us politically as we stand together to support AMPAC and ensure that we as physicians maintain a strong voice, a powerful voice and an effective voice in Washington, D.C. on behalf of our patients and our patients. Mahalo!

REPORT OF THE AMPAC BOARD OF DIRECTORS: The following report was submitted by Vidya Kora MD, Chair of AMPAC:

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities preparing for the 2018 Congressional Elections. Our mission is to provide physicians with a tangible means of advocating for organized medicine. On behalf of our physician members, AMPAC supports candidates who have demonstrated their support for organized medicine, including a willingness to work with physicians to strengthen our ability to care for America's patients. We work hand-in-hand with our state medical society PAC partners to carry out this mission. In addition, we strive to involve more physician advocates in our political education programs, which include intensive training sessions to give participants the tools necessary to successfully work on a campaign or run for office themselves.

AMPAC Membership Fundraising

In the 2016 election cycle, AMPAC raised nearly \$2.4 million dollars and played a significant role in influencing 2016 election outcomes. In total, AMPAC invested nearly \$2 million in the 2016 cycle and achieved a 91 percent success rate of supported candidates. As we head into the final stretch of the 2017 fundraising cycle, overall AMPAC has raised \$1,042,848. With the 2018 midterm elections well underway, it is critical that AMPAC's participation be at an all-time high in order to remain effective this election cycle.

After last year's record breaking year of HOD AMPAC participation, we are happy to report that participation for 2017 stands at 77 percent, surpassing last year's record. For those of you who contributed to AMPAC in 2017—thank you! Out of the 77 percent of HOD members that contribute to AMPAC, 63 percent participate at the Capitol Club level. HOD Capitol Club participation has 242 members including 25 Platinum members, 96 Gold members and 121 Silver members. If you have not made a 2017 contribution to AMPAC yet, we need your support now more than ever as we head into an important election year. I strongly encourage you to stop by the AMPAC booth today to join or renew your membership for 2018.

AMPAC is also excited to announce the winner of its 2017 Festival of Fall Colors Sweepstakes during the opening session of the House of Delegates. The winner will receive accommodations for 4 days/3 nights at Twin Farms Resort and Spa in Barnard, Vermont in September 2018. All 2017 Platinum, Gold and Silver contributors were automatically entered into the drawing for the sweepstakes.

Political Action

This year, health care was once again the focus of Capitol Hill and brought forward issues of keen interest to medicine. Votes and discussions on health system reform, MACRA, drug price transparency, and the ongoing opioid epidemic are highlighting the integral role the AMA and AMPAC have in helping to ensure medicine has a seat at the table. With these and other important issues in mind, we are preparing for another robust election cycle in 2018. AMPAC has already made \$185,200 in political contributions so far this year. The AMPAC Board's Congressional Review Committee will soon be working to set a comprehensive budget for all House and Senate candidates running this cycle. Medicine-friendly candidates, lawmakers in positions of leadership or on committees that deal with medicine's top issues, in addition to those legislators who are otherwise in unique positions to favorably impact key legislation are our top priorities.

In a political landscape that seems increasingly volatile and uncertain, AMPAC is dedicated to remaining a reliable constant for medicine and continues to be involved with important U.S. House and Senate races all over the country.

Political Education Programs

Utilizing a new programmatic model, this year's two political education programs were an overwhelming success. In February, 22 physicians and medical students took part in the 2017 Candidate Workshop held in Washington, DC. During the one and a half day program, participants learned from a bi-partisan group of political experts how and when to make the decision to run; the importance of a disciplined campaign plan; the secrets of effective fundraising and what kinds of media advertising are right for your campaign. And the program has already had its first success story - I am pleased to report that one of those participants, Dr. Kay Kirkpatrick, won her special election race for Georgia state senate.

More recently, on October 26-29, 21 physicians and medical students took part in AMPAC's 2017 Campaign School, held at the AMA's Washington, DC headquarters. Participants were provided a hands-on learning experience featuring political experts from both sides of the aisle providing expert instruction on how to run a winning campaign. Sessions included topics such as: crisis management, public speaking, social media utilization, and, in general, how to run a disciplined and effective campaign.

Both of these programs have received excellent feedback from the physicians who took part and building on that success, AMPAC is proud to announce the dates for the 2018 Candidate Workshop: March 2-4 at the AMA Washington, D.C. office. Running for political office can be an overwhelming task, and our team of political veterans gives participants expert advice about the nature of politics and the sacrifices needed to mount a

competitive campaign. The AMPAC Candidate Workshop continues to be a valuable tool, equipping physicians to be successful in their campaigns.

For more information on any of the Political Education Programs please stop by the AMPAC and AMA Grassroots booths during this meeting, or visit ampaonline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates for your continued support of AMPAC. Your involvement in political and grassroots activities ensures organized medicine continues to have a powerful voice in Washington, DC.

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