

REPORTS OF REFERENCE COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES 2016 ANNUAL MEETING

REPORT OF THE REFERENCE COMMITTEE ON *CODE* MODERNIZATION

- (1) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 – MODERNIZED
CODE OF MEDICAL ETHICS

RECOMMENDATION:

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

HOD ACTION: Council on Ethical and Judicial Affairs Report 2 adopted as amended by the Council on Ethical and Judicial Affairs.

To ensure that the nature of the *Code* is clear for readers, subject to review by the Office of General Counsel of the American Medical Association, the Council adds the following language to follow each Opinion: “This Opinion is offered as ethics guidance for physicians and is not intended to establish standards of clinical practice or rules of law.”

The Council amends draft updated Opinion 4.2.3, Therapeutic Donor Insemination, paragraph (a) by deletion of proposed new guidance to read as follows: “Provide therapeutic donor insemination in a nondiscriminatory manner. Physicians should not withhold or refuse services on the basis of nonclinical considerations, such as a patient’s marital status. ~~Physicians whose personal moral beliefs would prohibit them from providing therapeutic donor insemination without regard to nonclinical considerations should refer the patient to another qualified specialist.~~”

In 2008, the Council on Ethical and Judicial Affairs 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*.

At the 2015 Interim Meeting, a special Reference Committee was convened, dedicated solely to the modernized *Code*. Testimony raised concerns about the following: existing guidance on physician-assisted suicide; lack of clarity that the modernized *Code* provides guidance, not regulation; the need for a glossary; technical problems regarding access to the draft modernized *Code*; the process by which this draft modernized *Code* had been brought to the House of Delegates; and confusion about the scope of *Code* modernization. After careful consideration, your Reference Committee concluded that it was within the best interest of our AMA to ask the Council to make further clarifications to the *Code*. Therefore, the item was referred. Since that time, the Council has received additional comments on the *Code*, and devoted considerable time to discussing and responding to those comments. The

Council's feedback was posted online in April. Many of the comments were incorporated into this latest iteration of the draft. The Speakers have welcomed back your Reference Committee to this 2016 Annual Meeting.

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 was heard on the Preamble or Chapters 3 and 10. Your Reference Committee spent considerable time reviewing all testimony from each of the remaining items of business and thanks the House of Delegates for its attention to detail, as it shows great respect for the stature and integrity of the *Code*. In some instances, testimony addressed changes already incorporated into the draft modernized Code in keeping with feedback received by the Council prior to its March 2016 meeting. Some testimony also 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 notes that in some cases testimony appeared to be simple preference for alternative language or indicated misunderstanding of the context of a passage.

Impassioned testimony was offered to the effect that the Preface by itself did not sufficiently address concern that the modernized *Code* could be misinterpreted or misused and thereby expose physicians to legal or disciplinary actions. Some testimony suggested that the Council consider eliminating the use of "must" entirely. Other testimony proposed new language to be inserted throughout the *Code* to foreclose such unintended consequences. Your Reference Committee also heard testimony that in some instances proposed new guidance could have discriminatory effect.

Finally, your Reference Committee also heard testimony suggesting that a "parking lot" be established to collect issues for the Council to review as a priority on completion of the project to modernize the *Code*.

Prior to the conclusion of deliberation by your Reference Committee, the Council on Ethical and Judicial Affairs advised the Committee that the Council conferred following the conclusion of testimony and would amend the draft modernized *Code*.

Your Reference Committee commends the Council on Ethical and Judicial Affairs and the members of this House of Delegates for their collaboration and collegiality in undertaking this important project to ensure that the *Code of Medical Ethics* continues to articulate the highest ethical standards of our profession.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

(1) BOARD OF TRUSTEES REPORT 2 - NEW SPECIALTY ORGANIZATIONS
REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

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

HOD ACTION: Board of Trustees Report 2 adopted.

Board of Trustees Report 2 recommends that the American Society of Dermatopathology be granted representation in the AMA House of Delegates. The report outlines the guidelines for representation in and admission to the House of Delegates pertaining to National Specialty Societies, including a description of responsibilities for these organizations, and finds that the American Society of Dermatopathology has met these requirements.

Testimony provided for this report was limited, but in strong support of the report with no opposition. Your Reference Committee recommends that Board of Trustees Report 2 be adopted.

(2) BOARD OF TRUSTEES REPORT 28 - SPECIALTY SOCIETY REVIEW IN
THE HOUSE OF DELEGATES - FIVE YEAR REVIEW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 28 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 28 adopted.

Board of Trustees Report 28 recommends that the AMDA – The society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, and the Society of Critical Care Medicine retain representation in the American Medical Association House of Delegates. Board of Trustees Report 28 further recommends that the American Association of Clinical Endocrinologists, American Association of Hip and Knee Surgeons, American Society of Neuroimaging and the Society of Interventional Radiology be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. Finally, Board of Trustees Report 28 recommends that the American Society of Hematology and the International Society of Hair Restoration Surgery not retain representation in the House of Delegates for failure to meet required standards after a year's probation.

Testimony provided was strongly against the third recommendation of this report. Those offering testimony spoke in favor of keeping the American Society of Hematology and the International Society of Hair Restoration Surgery in the House of Delegates, noting the importance of these specialties and their prominence in medical circles. During its deliberations, however, the reference committee noted that these societies were already given two years to work on their membership to retain their place in the House of Delegates. Further, AMA Bylaw 8.5.3.2.2 notes that “the specialty society or professional interest medical association [who has been terminated] shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.” Your Reference Committee urges these societies to reapply when appropriate per the bylaws outlined above.

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

RECOMMENDATION:

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

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

Council on Ethical and Judicial Affairs Report 1 examines the ethical and professional responsibilities of physicians who practice through the utilization of telemedicine. Physicians who offer health care services via 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 strongly supported adoption of this report. The majority of testimony welcomed the ethical guidance of the report on telemedicine given the quickly evolving nature of technology and its effect on the practice of medicine. Many understood that ethical guidance in this area may require revisiting these guidelines in the future, but that the practice of telemedicine is happening now and direction is needed to help physicians traverse this complex set of issues. Some offering testimony identified language within the report that they believe remains unclear, asking for and receiving clarification from the Council and Ethical Judicial Affairs. The reference committee feels that the guidance provided by the report is timely and necessary, and encourages the Council on Ethical and Judicial Affairs to continue to provide definitions for key terms used in its recommendations. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted.

(4) RESOLUTION 004 - TARGETED EDUCATION TO INCREASE ORGAN DONATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 004 be adopted.

HOD ACTION: Resolution 004 adopted.

Resolution 004 addresses concerns for the limited participation from minority populations in donating organs, recognizing the reluctance to donate to be perpetuated by misconceptions and limited exposure to accurate information. The resolution asks that our AMA study potential educational efforts on the issue of organ donation tailored to demographic groups with low organ donation rates.

All testimony offered was in favor of this resolution. Testimony provided statistical support to emphasize the importance of pursuing efforts to address the disparities in organ donation between demographic groups. Therefore, your Reference Committee recommends that Resolution 004 be adopted.

(5) RESOLUTION 007 - MEMBERSHIP AND REPRESENTATION IN THE ORGANIZED MEDICAL STAFF SECTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 007 be adopted.

HOD ACTION: Resolution 007 adopted.

Resolution 007 asks our AMA to amend the current Bylaws for the Organized Medical Staff Section (OMSS) in order to promote a more inclusive membership model to gain adequate representation and participation in the Section. The resolution seeks to extend the allowance of membership in OMSS to include all active physician members of the AMA who are members of a medical staff, including select residents and fellows.

No testimony followed the introduction of this resolution. Your Reference Committee found the resolution to be very comprehensive and recommends that Resolution 007 be adopted.

(6) RESOLUTION 008 - UPDATING SEXUAL ORIENTATION AND GENDER IDENTITY POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 008 be adopted.

HOD ACTION: Resolution 008 adopted.

Resolution 008 seeks to amend the title of HOD policy H-160.991, Health Care Needs of the Homosexual Population, to read, Health Care Needs of Lesbian, Gay, Bisexual, and Transgender Populations. Furthermore, the resolution asks our AMA to modify the text of the policy to use current LGBTQ language.

This resolution was given strong testimonial support, encouraging modification of the noted policy to reflect current, accepted LGBTQ language. Therefore, your Reference Committee recommends that Resolution 008 be adopted.

(7) RESOLUTION 016 - SOCIAL MEDIA TRENDS & THE MEDICAL PROFESSION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 016 be adopted.

HOD ACTION: Resolution 016 adopted.

Resolution 016 asks that our AMA ask the Council on Ethical and Judicial Affairs to reconsider AMA Ethical Opinion E-9.124, Professionalism in the Use of Social Media based on the fact that the social media landscape has changed significantly since the opinion was originally issued in 2011.

The only testimony offered was in support of the resolution. Your Reference Committee found no issue with the resolution, and recommends that Resolution 016 be adopted.

(8) RESOLUTION 001 - SUPPORT FOR PERSONS WITH INTELLECTUAL DISABILITIES TRANSITIONING TO ADULTHOOD

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 001 be adopted.

HOD ACTION: Resolution 001 adopted with a change in title.

RECOMMENDATION B:

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

SUPPORT FOR PERSONS WITH INTELLECTUAL DISABILITIES

Resolution 001 discusses the lack of psychosocial resources available to persons with intellectual disabilities in the transition to adulthood, recognizing a need for improved planning to address the limited availability of employment, lack of independent social life, and limited funding and provision of equipment and support outside the home for individuals. The resolution asks that our American Medical Association encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

All testimony offered was strongly in favor of this resolution, recognizing it to be a timely and appropriate response to address the barriers faced by individuals with intellectual disabilities in the transition to adulthood. Testimony did, however, recognize that the lack of support persists throughout one's life, and is not limited to the isolated transition into adulthood. Therefore, your Reference Committee recommends that Resolution 001 be adopted with change in title.

(9) REPORT OF THE SPEAKERS 2 - PROCEDURES OF THE HOUSE OF DELEGATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Report of the Speakers 2 be amended by addition of a new recommendation to read as follows:

2. The rules and procedures of the House of Delegates will be amended as follows:

A. The motion to table a Report or Resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.

B. A new motion is added to the House of Delegates Reference Manual, "Object to Consideration". If a Delegate objects to consideration of an item of business by our HOD the correct motion is to Object to Consideration. The motion requires a ¾ supermajority vote for passage. The motion is not debatable, cannot interrupt a speaker, requires a second, cannot be amended, takes precedent over all subsidiary motions, and cannot be renewed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that recommendation 5 in Speakers Report 2 be amended by addition and deletion to read as follows:

5. That late resolutions be defined as those submitted less than 30 days before the opening day of a House of Delegates meeting but before the opening session recesses and not meeting the definition of regular business, and that business submitted after the recess of the opening session be regarded as emergency business, subject to a three-fourths vote for acceptance ~~as business, but needing only a majority vote for final action.~~ (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in the Report of the Speakers 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Report of the Speakers 2 adopted as amended.

Report 2 of the Speakers responds to the charge from I-15 to study and assess the alignment of the House of Delegates Reference Manual with the current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* and recommend appropriate changes to the Manual. The report proposes the formal adoption of three special rules to provide clarification for parliamentary procedure in the House of Delegates. Furthermore, the report recommends streamlining late and emergency resolutions to the full House of Delegates.

Testimony was strongly in favor of the spirit of the report and its proposals. Those lauding the report noted its emphasis on maintaining the deliberative process of the House of Delegates as well as the traditions it embodies. Several amendments were discussed to potentially strengthen the report in its current form and to remedy procedural deficiencies that have taken place in past proceedings of the House of Delegates. Of particular concern, testimony highlighted issues around tabling debate for items of business that many feel should not be addressed by the House of Delegates, while others worried about censoring minority views. Your reference committee thought that a higher bar should be established for tabling the debate of items considered to be inappropriate for deliberation. In addition, there was discussion over whether the motion can be debatable, and the committee concurred with testimony that making it not debatable further raised the bar. Finally, your reference committee felt that renaming, in effect creating a new motion, further clarifies the issue. Therefore, your Reference Committee recommends that Report of the Speakers 2 be adopted as amended.

(10) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 - CESSATION OF NEW AMA AFFILIATE MEMBERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Constitution and Bylaws Report 1 be amended by addition and deletion on page 1, line 19 to read as follows:

Those individuals who were elected as affiliate members prior to 2015 ~~will~~ may retain their affiliate membership.

RECOMMENDATION B:

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

HOD ACTION: Council on Constitution and Bylaws Report 1 adopted as amended.

Council on Constitution and Bylaws Report 1 presents amended bylaw language for consideration of the House of Delegates regarding affiliate membership, and requests that Policy G-635.064 be rescinded.

Testimony given for this report was limited to one proposed amendment, modifying brief language to more accurately reflect the intention of the report. There was no further testimony offered. With this consideration, your Reference Committee recommends that Council on Constitution and Bylaws Report 1 be adopted as amended.

(11) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2 - OPTIONS FOR INFORMATIONAL REPORTS SUBMITTED TO THE HOUSE OF DELEGATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 be amended by addition to read as follows:

2) The House of Delegates will have the following options to dispose of an informational report: file, refer, and not accept. An informational report may be

amended to add a recommendation for further action. An informational report, like any other report, also can be amended for clarity and/or accuracy with the concurrence of the author. If an informational report is amended for action, it is no longer considered an informational report. The House may also grant the author leave to withdraw an informational report. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 2 adopted as amended.

Council on Constitution and Bylaws Report 2 presents four recommendations for appropriate action with regard to informational reports. First, informational reports will be included in the AMA House of Delegates Online Member Forum. Second, the House of Delegates will have the following options to dispose of an informational report: file, refer, and not accept. Third, any informational report that the House of Delegates votes to not accept will be published in the Proceedings in its entirety, but be clearly labeled with the House action. Fourth, the Proceedings of our AMA House of Delegates meetings will use a prominent “not accepted” watermark to designate any informational report that the House votes to not accept.

Testimony provided on this report was limited and divided equally between those in favor of and against its recommendations. Concern was voiced about outside parties gaining access to informational reports that are not adopted, and misinterpreting the distinction between items that have been adopted and those that have not. Other testimony, however, welcomed the availability of informational reports that have not been adopted in the House of Delegates proceedings in order to accurately represent those proceedings. To further clarify the handling of informational reports, the Council on Constitution and Bylaws provided an amendment to clarify what can and cannot be done with those reports. In light of testimony and the amendment offered, your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted as amended. These procedures should be incorporated into the next edition of the House of Delegates Reference Manual.

(12) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 - CEJA'S SUNSET REVIEW OF 2006 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Ethical and Judicial Affairs Report 3 be amended by addition on page 2, line 33 to read as follows:

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of H-140.872, which should be retained, and the remainder of the report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation contained in Council on Ethical and Judicial Affairs Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 adopted as amended.

Council on Ethical and Judicial Affairs Report 3 presents the annual sunset report of House policies. This report reviewed House policies from 2006. This report recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated.

The Council on Ethical and Judicial Affairs introduced this report. They noted that policy H-140.872 is designated to be rescinded based on the duplicative policy of E-8.056 Physician Pay-for-Performance Programs. However, E-8.056 was rescinded when it was combined with several other opinions to form E-8.131 Professionalism in Health Care Systems (issued June 2014). Therefore, CEJA recommends that policy H-140.872 be retained. No other testimony was offered for this report. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be adopted as amended.

- (13) RESOLUTION 002 – CLARIFICATION OF MEDICAL NECESSITY FOR TREATMENT OF GENDER DYSPHORIA
RESOLUTION 005 - CLARIFICATION OF MEDICAL NECESSITY FOR TREATMENT OF GENDER DYSPHORIA

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 005 be amended by addition of a third resolve to read as follows:

RESOLVED, That our AMA amend Policy H-185.950 by addition and deletion to read as follows: (Modify Current HOD Policy)

H-185.950, Removing Financial Barriers to Care for Transgender Patients
Our AMA supports public and private health insurance coverage for treatment of gender ~~identity disorder~~ dysphoria as recommended by the patient's physician.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Resolution 005 be adopted as amended in lieu of Resolution 002.

HOD ACTION: Resolution 005 adopted as amended in lieu of Resolution 002.

Resolution 002 asks that our AMA acknowledge that treatment for gender dysphoria should be determined by shared decision making between patient and physician, citing examples of emerging standards of care and practice in treatment of gender dysphoria. Furthermore, the resolution asks that our AMA amend HOD policy H-185.950 to remove language referring to gender dysphoria as a disorder, updating the terminology.

Resolution 005 asks our AMA for the adoption of new policy to promote adequate health care for persons with gender dysphoria. The resolution asks our AMA to establish that medical and surgical treatments for gender dysphoria are to be recognized as medically necessary when determined to be appropriate through shared decision making between the patient and physician. Furthermore the resolution encourages our AMA to advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

Testimony was unanimous in favor of adoption of both resolutions. Testimony for Resolution 002 highlighted the importance of creating policy that will help to erode existing barriers often faced by those with gender dysphoria, and that the resolution helps to further that effort. The policy goals of helping patients with gender dysphoria overcome obstacles in accessing medical care were lauded, and it was widely felt that the adoption of Resolution 005 would strengthen advocacy efforts at the federal, state, and local levels for providing care to this population.

Because these two resolutions are so similar, your reference committee feels that it is appropriate to combine them into one resolution. The first resolves of both Resolutions 002 and 005 were almost identical, but the reference

committee feels that the language of the first resolve of Resolution 005 more precisely addresses the medical and surgical needs of those with gender dysphoria.

The second resolve of Resolution 002 contains an amendment to current policy, and your Reference Committee felt it appropriate to add that policy change to Resolution 005.

Therefore, your Reference Committee recommends that Resolution 005 be adopted as amended in lieu of Resolution 002.

(14) RESOLUTION 006 - DEFINITION OF RESIDENT AND FELLOW

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 006 be amended by addition and deletion to read as follows:

2) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including ~~dive~~ undersea medical officers or flight surgeons) before their return to complete a residency program. ~~and are within the first five years of service after internship~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Resolution 006 be adopted as amended.

HOD ACTION: Resolution 006 adopted as amended.

Resolution 006 asks our AMA to develop amendments to the Bylaws to include definitions for “Resident” and “Fellow” and establish criteria for membership in the AMA Resident and Fellow Section.

Testimony provided for this item was predominantly in support of the resolution. However, brief testimony presented a concern for the ambiguity of the status of residents enrolled in active military duty for a second tour, exceeding the five year time constraint noted in the resolution. The testimony proposed an amendment to strike the references to specific time limitations in order to extend eligibility for membership. One person noted that the correct term for “dive” medical officers is “undersea” medical officers. Proposed amendments, with the rest of the resolution, were supported in following testimony. Your Reference Committee recommends that Resolution 006 be adopted as amended.

(15) RESOLUTION 009 - PHYSICIAN DECISION MAKING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 009 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate that treating and attending physicians, regardless of employment status, must maintain overall leadership in decisions affecting the health care received by patients in order to ensure quality of the care given to patients. ~~physicians, regardless of employment status, must maintain overall responsibility and leadership in decisions affecting the health care received by patients.~~ (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Resolution 009 be adopted as amended.

HOD ACTION: Resolution 009 adopted as amended.

Resolution 009 reaffirms the importance of the physician-patient relationship as the dominant groundwork for effective care, asking our AMA to advocate that physicians shall maintain overall responsibility and leadership in determining appropriate health care that is to be received by patients. This resolution stems from concerns that organizations or third-party payers may impact health care decision-making.

The testimony was overwhelmingly in support of the resolution, offering additional emphasis of the importance of physician leadership in patient care. A recommendation to modify language of the resolve to include specific identification of treating and attending physicians was supported. Therefore, your Reference Committee recommends Resolution 009 be adopted as amended.

(16) RESOLUTION 010 - RELIGIOUSLY AFFILIATED MEDICAL FACILITIES AND THE IMPACT ON A PHYSICIAN'S ABILITY TO PROVIDE PATIENT CENTERED, SAFE CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 010 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association conduct a study of hospital consolidations ~~access to care in secular hospitals and religiously affiliated hospitals~~ to include any impact on patient access to services resulting from ~~of~~ consolidation in secular hospital systems and religiously-affiliated hospital systems. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 010 be amended by addition and deletion in title to read as follows:

~~RELIGIOUSLY AFFILIATED~~ CONSOLIDATION OF MEDICAL FACILITIES AND THE IMPACT ON A PHYSICIAN'S ABILITY TO PROVIDE PATIENT CENTERED, SAFE CARE SERVICES

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Resolution 010 be adopted as amended with change in title.

HOD ACTION: Original Resolution 010 adopted.

Resolution 010 discusses the conflicts present in decision-making for health care providers employed by religiously-affiliated institutions. Given that the presence of religiously-affiliated hospitals continues to grow, caring for more than 1 in 6 patients, the resolution encourages our AMA to conduct a study of access to care in secular hospitals and religiously-affiliated hospitals to include any impact on access to services in the consolidation of systems.

Support for this resolution was overwhelmingly in favor of adoption. Testimony focused on the obstacles many patients face in trying to access basic medical care in the wake of hospital consolidations, specifically when a religiously-affiliated hospital assumes control of once-secular institutions. Personal anecdotes were offered detailing the denial of medical services for those seeking reproductive health care or the denial of testing and treatment by sexual minorities. In these instances, testimony spoke to upholding the independent health care decisions made by patients in consultations with their physicians without the intervention of an overarching hospital policy. Others

disagreed, noting that focusing on religion was inappropriate and drew attention away from the central issue: maintaining the sanctity of patient-physician relationship. Based on the testimony heard and its deliberations, your Reference Committee recommends that Resolution 010 be adopted as amended.

(17) RESOLUTION 011 - CEJA AND HOUSE OF DELEGATES
COLLABORATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 011 be amended by deletion to read as follows:

RESOLVED, That our AMA evaluate how a periodic review ~~and/or a sunset policy for~~ of Code of Medical Ethics guidelines and reports can best be implemented, and report back ~~at the 2016 Interim Meeting~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Resolution 011 be adopted as amended.

HOD ACTION: Resolution 011 adopted as amended.

Resolution 011 asks that our AMA explore options for improving the collaborative process between the HOD and CEJA in order to allow for HOD input while maintaining CEJA's autonomy. Furthermore, the resolution calls for evaluation of how a periodic review and/or sunset policy for the Code of Medical Ethics may be implemented.

Testimony provided for this item was divided, both in favor of and in opposition to the resolution. Testimony heard in favor of the resolution supported looking more closely into the collaboration between the Council on Ethical and Judicial Affairs and the House of Delegates, encouraging a more clearly delineated review process for the Code of Medical Ethics. Testimony in opposition argued against the consideration of sunset for ethics policy, noting the intention for ethics guidance to be timeless. With the testimony received, the committee agreed that sunset of ethics policy would not be appropriate, but encouraged the recommendation to look further into a periodic review process. The request for report back at I-16 is not feasible and therefore your reference committee has struck this. Your Reference Committee recommends that Resolution 011 be adopted as amended.

(18) BOARD OF TRUSTEES REPORT 15 - DESIGNATION OF SPECIALTY
SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 15 be referred.

HOD ACTION: Board of Trustees Report 15 referred.

Board of Trustees Report 15 puts forth five recommendations to determine appropriate allocation of specialty society delegates. First, that current specialty society delegation allocation system be discontinued and that specialty society delegate allocation in the House of Delegates be determined based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof, reduced by a factor of 25% to reflect multiple memberships, starting with the 2017 delegate apportionment. Second, that specialty societies that are in good standing according to the five-year review will continue to be allocated automatically at least one delegate without the submission of membership data annually. Third, that a transition period be established to allow specialty societies that would lose delegates with the new allocation system a one year grace period to increase membership and if necessary to downsize their delegation. Fourth, that after 2017, specialty societies that would lose delegate(s) based on declining membership be allowed a one-year grace period to increase their AMA membership and that their delegation remain

unchanged until the end of the grace period. Fifth, that the Council on Constitution and Bylaws investigate the need to amend any policy or bylaws.

The testimony offered on this report was mixed. Favorable testimony discussed the critical nature of retaining parity within the House of Delegates and creating an appropriate mechanism for determining the representation of specialty societies. In order to achieve this parity, new formulas for calculating specialty society representation were proposed that differed from the proposals of the report. While many of these proposed amendments were supported through the testimony, opponents of the report pointed out the harms that could result from delegate proportioning, particularly for larger societies. The strengths and weaknesses of the report and the subsequent proposed amendments were the basis for considerable debate, and the reference committee believes that the report offers an appropriate starting point for further discussions for achieving equitable representation within the House of Delegates. As a result, your Reference Committee recommends that Board of Trustees Report 15 be referred.

(19) RESOLUTION 003 - SUPPORTING AUTONOMY FOR PATIENTS WITH DIFFERENCES OF SEX DEVELOPMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 003 be referred.

HOD ACTION: Resolution 003 referred.

Resolution 003 discusses the controversy involved in the practice of reconstructive surgeries in patients with differences of sex development (DSD). The resolution argues against unnecessary alterations to ambiguous genitalia at birth in order to avoid irreversible outcomes that may negatively impact the patient. Given that DSD communities condemn genital “normalizing” and advocate for respecting patient autonomy in determining gender identity, the resolution encourages our AMA to affirm that medically unnecessary surgeries in individuals born with DSD are unethical, stating that surgery should be postponed, when possible, until the patient can actively participate in decision-making for treatment.

Testimony was largely in favor of referral. Those offering testimony understood the critical developmental issues surrounding those born with differences in sex development, however, there was considerable agreement that the resolution as presented could have unintended consequences regarding the decision making relationship between the physician and the parents. Furthermore, testimony revealed gaps in understanding on how to appropriately address the surgical and medical options for those born with difference of sex development, necessitating a call for further study. Therefore, your Reference Committee recommends that Resolution 003 be referred.

(20) RESOLUTION 014 - MEDICAL REPORTING FOR SAFETY SENSITIVE POSITIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 014 be referred for report back at I-16.

HOD ACTION: Resolution 014 referred for report back at I-16.

Resolution 014 discusses reporting requirements for physicians treating patients who operate in Safety Sensitive positions. The resolution asks that our AMA advocate for uniform policy on mandatory reporting of significant medical conditions for patients with conditions that may pose a risk to public safety while simultaneously enhancing protection of the reporting physicians.

Testimony given was supportive of the intent of the resolution, but was concerned for the ambiguity of language in light of the complexity of the issue. Testimony also offered amendments to include in the resolution a notation to “Safety Sensitive Positions” as defined by the FAA/DOT. It was expressed that, while addressing this issue as timely and necessary, clarification must be provided before the resolution is recommended for adoption. Testimony

further noted that the FAA and EU will be convening to review their policies on this issue, and therefore report back at I-16 would be preferable. After deliberation, your Reference Committee recommends that Resolution 014 be referred.

(21) RESOLUTION 015 - STUDY AID-IN-DYING AS END-OF-LIFE OPTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 015 be referred.

HOD ACTION: Resolution 015 referred.

Resolution 015 asks that our AMA and its Council on Ethical and Judicial Affairs study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-in-dying”.

Support for this resolution was largely in favor of the Council on Ethical and Judicial Affairs studying the issue of medical aid-in-dying. The testimony spoke to the fact that many states have proposed or adopted legislation to legalize the practice, introducing a potential conflict for our members in those states. Additional testimony recognized the need for our American Medical Association to respond to this highly relevant and expanding issue that may impact medical practice, looking to the Council for guidance. With these considerations in mind, your Reference Committee recommends that Resolution 015 be referred.

(22) RESOLUTION 012 - OPPOSITION TO PHYSICIAN ASSISTED SUICIDE AND EUTHANASIA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 012 not be adopted.

HOD ACTION: Resolution 012 not adopted.

Resolution 012 addresses the recent developments encouraging reconsideration of AMA policies concerned with physician assisted suicide and euthanasia, noting that the Council on Ethical and Judicial Affairs has received testimony to reexamine existing guidance. This resolution asks that our AMA not change its policies on opposition to physician-assisted suicide or euthanasia to policies of neutrality or endorsement on the issue of physician-assisted suicide or euthanasia.

While testimony was heard in support of the resolution, a strong majority presented in opposition, stating it would be imprudent for our American Medical Association to reaffirm the existing policy without consideration for study. From these prevalent concerns, your Reference Committee recommends that Resolution 012 not be adopted.

(23) RESOLUTION 013 - MODERNIZATION OF THE AMA CODE OF MEDICAL ETHICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 013 not be adopted.

HOD ACTION: Resolution 013 not adopted.

Resolution 013 asks that our AMA amend its Bylaws so that any proposed revisions or modernizations to our AMA Code of Medical Ethics will be presented to the member societies of the Federation of Medicine at least six months prior to the session of our AMA House of Delegates. The resolution asks that changes to the Code be presented for affirmation on a chapter by chapter basis, with the House of Delegates having the ability to extract any item for debate and amendment before a final vote on each chapter.

Testimony for this resolution was largely against adoption. While there was limited testimony stating that an ongoing process of review for the Code of Medical Ethics could serve as a means of continuous quality improvement, most spoke to the independence of the Council on Ethical and Judicial affairs and the transparency of its processes in developing ethics policy. Frustration with the policy development of the Council on Ethical and Judicial Affairs may stem from the challenging nature of the questions it is charged with addressing, and, as was noted in testimony, a chapter-by-chapter review of the Code and its interpretations would not be possible. Therefore, your Reference Committee recommends that Resolution 013 not be adopted.

REPORT OF REFERENCE COMMITTEE A

(1) RESOLUTION 122 - HEALTH COVERAGE FOR NUTRITIONAL PRODUCTS FOR INBORN ERRORS OF METABOLISM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 122 be adopted.

HOD ACTION: Resolution 122 adopted.

Resolution 122 asks that our AMA support legislation mandating insurance coverage with minimal deductible or copays for specialized medical food products used to treat inborn errors of metabolism and advocate with the Department of HHS and members of Congress for the regulation of specialized nutritional products for the medical treatment of inborn errors of metabolism as drugs.

Testimony on Resolution 122 was mixed. The sponsor emphasized that health coverage for nutritional products for inborn errors of metabolism is essential as these medical foods can be expensive and failure to treat these conditions can result in debilitating health conditions and even death. An amendment was submitted to include all foods used to treat chronic medical conditions; however, your Reference Committee believes that coverage should be limited to inborn errors of metabolism that are objectively tested for and diagnosed upon birth. While the intent of Resolution 122 is consistent with existing policy, your Reference Committee heard compelling testimony from the sponsor of Resolution 122 to adopt more current, focused policy.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 - SUNSET REVIEW OF 2006 AMA HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be amended by the addition of a new Recommendation 2 to read as follows:

That the title of Policy H-220.977 be amended by addition and deletion as follows:

CHIEF EXECUTIVE OFFICER AT MEDICAL STAFF EXECUTIVE
~~SESSION~~ COMMITTEE

RECOMMENDATION B:

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

HOD ACTION: Council on Medical Service Report 1 adopted as amended.

Council on Medical Service Report 1 contains recommendations for socioeconomic policies adopted or reaffirmed by the House in 2006.

A member of the Council on Medical Service introduced Council on Medical Service Report 1. One speaker testified that Policy H-345.980 should not be amended as recommended by the Council. The speaker stated that changing “addiction” to “mental health” in the policy would preclude coverage of gambling. However, your Reference Committee notes that gambling is now considered a mental health disorder such that the Council’s recommended change still includes gambling treatment. Further, your Reference Committee proposes a title

change to Policy H-220.977 to reflect the proper terminology for a medical staff executive committee and to mirror terminology in the body of the policy. Accordingly, your Reference Committee recommends that Council on Medical Service Report 1 be adopted as amended and the remainder of the report filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 2 – AFFORDABLE CARE
ACT MEDICAID EXPANSION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 2 be amended by addition on page 12, line 2 to read as follows:

6. That our AMA advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 9 in Council on Medical Service Report 2 be amended by addition and deletion on page 12, line 11, to read as follows:

9. That our AMA support ~~enhancing~~ increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings ~~in order~~ to encourage physician participation and increase patient access to care. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 10 in Council on Medical Service Report 2 be amended by addition and deletion on page 12, lines 17-18 to read as follows:

10. That our AMA continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can ~~access necessary services in a timely manner~~ have equal access to necessary services. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Recommendation 15 in Council on Medical Service Report 2 be amended by addition and deletion on page 12, lines 34-36 to read as follows:

15. That our AMA support the use of emergency department (ED) best practices that are evidenced-based ~~such as for employing ED navigators; using electronic health information; providing patient education; identifying frequent ED users and developing care plans; monitoring prescriptions; and using feedback information~~ to reduce ~~inappropriate~~ avoidable ED use-visits. (New HOD Policy)

RECOMMENDATION E:

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

HOD ACTION: Council on Medical Service Report 2 adopted as amended.

Council on Medical Service Report 2 emphasizes that access to care and adequate physician payment are intrinsically linked, and mechanisms to ensure adequate provider payment need to be developed; research conclusions on the quality and outcomes of primary and specialty care services for Medicaid expansion beneficiaries are mixed, highlighting the need for additional study; and the current and projected federal costs of the Medicaid expansion are of great concern. The report presents a series of recommendations based on an extensive analysis.

Testimony on Council on Medical Service Report 2 was supportive of the Council's extensive analysis and comprehensive recommendations. A member of the Council introduced the report and emphasized that Medicaid expansion is the biggest medical delivery system reform in recent years and is highly complex. The impact of specific elements of the expansion are still unclear, such as the extent of access to quality care. Key recommendations urge states to include adequate physician payment as state Medicaid expansion goals and that maintenance of federal funding for Medicaid expansion populations continue at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

Several minor amendments were suggested. The American Academy of Pediatrics (AAP) requested that the report's recommendations address the fact that access to specialty care for pediatric patients is especially difficult and that equal access to necessary services be emphasized. The AAP also suggested that the maintenance of federal funding for Medicaid expansion populations not continue at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists. Your Reference Committee concurs with the Council on Medical Service that this level of federal funding needs to stay in place as states have concerns that the federal government will discontinue the 90 percent contribution and are making determinations on whether to expand Medicaid accordingly.

Concerns were voiced that some of the recommendations appear broad and possibly difficult to implement; however, your Reference Committee supports the Council's intention to word the recommendations in a way that allows for flexibility in AMA advocacy efforts. An amendment was offered by the American College of Emergency Physicians to strike examples of emergency department best practices in Recommendation 15 and to instead focus on evidence-based practices in general. Your Reference Committee recommendations reflect ACEP's suggestion.

(4) COUNCIL ON MEDICAL SERVICE REPORT 3 - PAID SICK LEAVE

RECOMMENDATION A:

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

3. That our AMA support ~~voluntary~~ employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Council on Medical Service Report 3 adopted as amended.

Council on Medical Service Report 3 recommends that our AMA support voluntary employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member, and support employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome. The report acknowledges the public health benefits of paid sick leave while recognizing that this is both a public health and employer issue.

There was unanimous supportive testimony on Council on Medical Service Report 3. An amendment was offered to strike “voluntary” from Recommendation 3 to underscore the importance of paid sick leave and other discretionary time off. Your Reference Committee accepts this amendment. It believes that it neither changes the intent of the report nor does it direct the AMA to advocate for mandatory employer policies on paid sick leave. As such, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(5) COUNCIL ON MEDICAL SERVICE REPORT 4 - ACCESS TO SELF-ADMINISTERED MEDICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 4 be amended by deletion to read as follows:

That our American Medical Association (AMA) support legislation that prohibits health insurance and pharmacy benefit management (PBM) companies from denying early prescription refills for solutions, ointments, gels, creams, nasal sprays, and other formulations that are difficult and/or imprecise to self-administer, ~~excluding controlled substances~~. (New HOD Policy)

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: Council on Medical Service Report 4 adopted as amended.

Council on Medical Service Report 4 recommends that the AMA support legislation prohibiting health insurance and pharmacy benefit management companies from denying early prescription refills for medications that are difficult and/or imprecise to self-administer, excluding controlled substances, and recommends that interested national medical specialty societies and other stakeholders continue to advocate on the state level and work with health insurance and pharmacy benefit management companies to re-evaluate their refill policies on medications that are difficult and/or imprecise to self-administer to allow for early refills as needed.

Positive testimony was heard on Council on Medical Service Report 4. The American Academy of Ophthalmology (AAO) spoke in favor of Council on Medical Service Report 4 and emphasized that running out of ophthalmic medications is a serious issue. Many patients in need of ophthalmic medications are elderly and have difficulties administering precise doses and then have difficulty filling their prescriptions. Testimony from the American Society of Clinical Oncology (ASCO) acknowledged it is understandable that there are serious concerns about allowing for early refills of controlled substances. However, denying early prescription refills of pain medications for cancer patients, such as opioids, could compromise their health. ASCO therefore suggested striking the language “excluding controlled substances” in the first recommendation, particularly recognizing that it will be rare for a control substance to be difficult and/or imprecise to self-administer. Your Reference Committee concurs with ASCO’s suggested amendment and therefore recommends that Council on Medical Service Report 4 be adopted as amended.

(6) COUNCIL ON MEDICAL SERVICE REPORT 9 - PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 9 be amended by addition and deletion as follows:

4. That our AMA support that the following goals be pursued as part of an APM:

- a. Be designed by physicians or with significant input and involvement by physicians;
- b. Provide flexibility to physicians to deliver the care their patients need;
- c. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
- ~~e.~~ d. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
- ~~f.~~ e. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
- ~~g.~~ f. Avoid placing physician practices at substantial financial risk;
- ~~h.~~ g. Minimize administrative burdens on physician practices; and
- ~~i.~~ h. Be feasible for physicians in every specialty and for practices of every size to participate in. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Council on Medical Service Report 9 adopted as amended.

4. That our AMA support that the following goals be pursued as part of an APM:

- a. Be designed by physicians or with significant input and involvement by physicians;**
- b. Provide flexibility to physicians to deliver the care their patients need;**
- c. Promote physician-led, team-based care coordination that is collaborative and patient-centered;**
- d. Reduce burdens of Health Information Technology (HIT) usage in medical practice;**
- ~~e.~~ d. e. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;**
- ~~f.~~ e. f. Limit physician accountability to aspects of spending and quality that they can reasonably influence;**
- ~~g.~~ f. g. Avoid placing physician practices at substantial financial risk;**
- ~~h.~~ g. h. Minimize administrative burdens on physician practices; and**

~~g. h. i.~~ Be feasible for physicians in every specialty and for practices of every size to participate in.

Council on Medical Service Report 9 recommendations build off the AMA's current MACRA advocacy efforts and propose principles to guide the development and implementation of alternative payment models to create foundational policy.

There was generally supportive testimony on Council on Medical Service Report 9. A member of the Council on Medical Service introduced the report stating that it is the result of a six year genesis in health care reform stemming from the Affordable Care Act (ACA) and through the Medicare Access and CHIP Reauthorization Act (MACRA). Several suggested amendments were offered. It was suggested that Recommendation 4(a) be amended to include the word "practicing" before the mentions of physicians stating that practicing physicians are best poised to provide input and involvement in the development of APMs. Your Reference Committee appreciates this amendment; however, it finds this narrowing and potentially disenfranchising to other physicians who happen to not be practicing at any given time. Additionally, your Reference Committee received an amendment to encourage the effective use of health information technology. While your Reference Committee appreciates this suggestion, it believes any further dictation on the use of health information technology may be burdensome and highlights Recommendation 6 that, among other things, encourages the sharing of tools, resources, and data; encourages assistance obtaining the data and analysis needed to participate in an APM; and encourages assistance in obtaining resources needed to transition to new payment models, which may include financial assistance obtaining the appropriate health information technology. Further, your Reference Committee received an amendment to protect physicians from having to provide uncompensated care under failed plans. While your Reference Committee agrees with the spirit of this suggested amendment, it finds the amendment to be outside the scope of this report and not germane to the issue of financial risk as outlined in this report.

Additionally, your Reference Committee received separate suggestions to include the goals of effective care coordination and collaborative, patient-centered care, and offers an amendment to Recommendation 4 recognizing the value of both suggestions.

Your Reference Committee received testimony outlining problems with MACRA. In response, a member of the Council reiterated that the scope of this report is limited to physician-focused payment models and is not intended to cover all of MACRA. While your Reference Committee appreciates and concurs with the testimony outlining potential drawbacks of MACRA, it notes that the AMA already has been actively advocating on behalf of physicians to ensure this transition is physician-led, feasible, and protects a physician's choice of practice and method of earning a living. To that end, your Reference Committee highlights recent advocacy efforts including the formation of a MACRA Task Force comprised of national medical organizations and state medical organizations and working with Federation workgroups established to review both MIPS and APMs, among other activities. Further, the AMA has created a number of resources to educate physicians.. These resources can be obtained at: <http://www.ama-assn.org/go/medicarepayment>.

Your Reference Committee commends the Council on a comprehensive and timely report promulgating foundational policy on physician-focused APMs. Accordingly, your Reference Committee recommends that Council on Medical Service Report 9 be adopted as amended.

(7) **RESOLUTION 101 - INCREASING AVAILABILITY AND COVERAGE FOR IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTIVE PLACEMENT**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 101 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association recognize the practice of immediate postpartum and post pregnancy ~~post abortive~~ long-acting reversible

contraception placement to be a safe and cost effective way of reducing future unintended pregnancies. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 101 be amended by addition and deletion as follows:

RESOLVED, That our AMA support the coverage of ~~immediate postpartum long-acting reversible contraception device and placement~~ by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that ~~these this service~~ be billed separately from the obstetrical global fee. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 101 be adopted as amended.

HOD ACTION: Resolution 101 adopted as amended.

Resolution 101 asks that our AMA recognize the practice of immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee; and encourage relevant specialty organizations to provide training for physicians regarding (1) patients who are eligible for immediate postpartum long-acting reversible contraception, and (2) immediate postpartum long-acting reversible contraception placement protocols and procedures.

Testimony was supportive of Resolution 101. Your Reference Committee received several suggested amendments. Your Reference Committee offers an amendment to the first Resolve to recognize the practice of both immediate postpartum and post pregnancy placement of long-acting reversible contraception (LARC) noting that postpartum encompasses the six weeks after delivery while the term “post pregnancy” refers to the 365 days following a pregnancy. Your Reference Committee received an amendment to distinguish between payment for the LARC device and payment for the placement of the device noting that the majority of the cost of LARC can be attributed to the devices themselves and that it is important to specify coverage for both the placement of the device and the device itself. The author found this amendment to be friendly, and your Reference Committee concurs.

Your Reference Committee received an additional amendment supporting the purchase of LARC devices by hospitals. Your Reference Committee does not find it appropriate for the AMA to request this of hospitals. Further, your Reference Committee received an amendment to add sterilization to the first Resolve; however, your Reference Committee does not find sterilization germane to this resolution.

Additional testimony expressed concern over the third Resolve clause being overly prescriptive. However, your Reference Committee finds the phrase as written to be both appropriate and beneficial and notes differing protocols and procedures for varying types of LARC warranting further physician education and training. Accordingly, your Reference Committee recommends Resolution 101 be adopted as amended.

(8) **RESOLUTION 102 - DEVELOPING MEASURES FOR GOOD ACCESS TO CARE**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 102 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~collaborate work~~ with the appropriate ~~organizations specialty societies~~ to support specialty-designed develop measures of access to care that ensure physicians have the measures they need to be successful under the Medicare Access and Chip Reauthorization Act (MACRA) measurements so that access to care for patients can be measured and improved. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 102 be adopted as amended.

HOD ACTION: Resolution 102 adopted as amended.

Resolution 102 asks that our AMA work with the appropriate specialty societies to develop access measurements so that access to care for patients can be measured and improved, and encourage CMS to use specialty society-developed access to care measures for the Clinical Practice Improvement incentives rather than CMS-generated measures of access.

There was generally supportive testimony on Resolution 102. Your Reference Committee appreciates the complexities of developing access to care measures and finds this resolution of great importance during this era of profound payment reform. Your Reference Committee offers an amendment to recognize that these measures should ensure physicians have the tools they need to be successful under MACRA. Further, your Reference Committee finds the second Resolve valuable. While the first Resolve calls for support of the development of measures, your Reference Committee notes that there is ongoing measure development, and believes it is appropriate to encourage CMS to use already-developed measures and to continue to adopt these specialty-developed measures over time. Accordingly, your Reference Committee recommends adopting Resolution 102 as amended.

(9) RESOLUTION 103 - DIRECT PRIMARY CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 103 be amended by addition and deletion on line 15 to read as follows:

RESOLVED, That our American Medical Association ~~work to include support~~ inclusion of Direct Primary Care as a qualified ~~Health Savings Account~~ medical expense by the Internal Revenue Service. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 103 be adopted as amended.

HOD ACTION: Resolution 103 adopted as amended.

Resolution 103 asks that our AMA work to include Direct Primary Care as a qualified HSA medical expense by the IRS.

Your Reference Committee heard mixed testimony on Resolution 103. The sponsor testified that the benefits of a Direct Primary Care (DPC) practice model support the patient-physician relationship and encourage patient responsibility. Several speakers agreed that a DPC practice can have advantages to both physicians and patients. A member of the Council on Medical Service testified that there is confusion about what a DPC model entails and suggested referral for study. Other speakers also questioned the definition of DPC and the difference between DPC and concierge practices. Your Reference Committee notes that DPC charges a periodic fee for services and does not bill a third party, whereas concierge practices do bill insurance.

Your Reference Committee notes that AMA policy supports pluralism in the delivery and financing of health care (Policies H-385.990 and H-165.920). Advocating that the monthly fee for Direct Primary Care services, but not advocating for other models, would conflict with the principles of pluralism. Accordingly, your Reference Committee recommends striking “health savings accounts” to maintain other options in the spirit of pluralism. Furthermore, to provide the AMA with flexibility in their advocacy efforts, your Reference Committee recommends replacing the phrase “work to include Direct Primary Care as a qualified medical expense by the Internal Revenue” with “support inclusion of Direct Primary Care as a qualified medical expense.”

(10) RESOLUTION 104 - PROVIDER EXPERIENCE AS A METRIC FOR DETERMINING OVERALL PERFORMANCE BY ACOS AND OTHER PAYMENT MODELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends deletion of the first Resolve of Resolution 104:

~~RESOLVED, That our American Medical Association urge federal CMS to include provider experience as a metric for determining overall performance by ACOs and other payment models based on MACRA (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 104 be amended by addition and deletion as follows:

~~RESOLVED, That our AMA support that study the benefits of adding a fourth dimension to the “Triple Aim”~~ be expanded to the Quadruple Aim, adding the goal of as a matter of federal health care policy that would include improving the work-life balance of physicians and other health care providers professionals. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends deletion of the third Resolve of Resolution 104:

~~RESOLVED, That our AMA report its findings to the House of Delegates in November 2016. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 104 be amended by the addition of a new Resolve to read as follows:

RESOLVED, That our AMA advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS). (Directive to Take Action)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 104 be adopted as amended.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that the title of Resolution 104 be changed to read as follows:

SUPPORT FOR THE QUADRUPLE AIM

HOD ACTION: Resolution 104 adopted as amended.

Resolution 104 asks that our AMA urge federal CMS to include provider experience as a metric for determining overall performance by ACOs and other payment models based on MACRA, study the benefits of adding a fourth dimension to the ‘Triple Aim’ as a matter of federal health care policy that would include improving the work-life of health care professionals, and report its findings to the I-16 HOD.

Your Reference Committee received mixed testimony on Resolution 104, largely in support of the spirit of the resolution. Several speakers requested that the first Resolve be struck due to ambiguity and the lack of standardized measures of physician experience, and your Reference Committee concurs. Instead, your Reference Committee recommends advocating that addressing physician satisfaction count as a Clinical Practice Improvement Activity, a performance category under the Merit-Based Incentive Payment System (MIPS).

Regarding the second Resolve clause, your Reference Committee received significant testimony outlining the importance of addressing and mitigating burnout in all stages of physician careers. Your Reference Committee notes that one of the AMA’s three strategic focus areas is to work with physicians to advance initiatives that enhance professional satisfaction, practice efficiency, and improve care delivery. Your Reference Committee notes that the AMA’s Physician Satisfaction and Practice Sustainability group continues to study the issue of physician burnout and satisfaction, and the group recently conducted a study with the RAND Corporation relating to physician satisfaction that has been submitted for publication. Your Reference Committee believes that burnout imperils the Triple Aim. Based on passionate testimony, a literature review of the Quadruple Aim, and current AMA efforts, your Reference Committee finds a sufficient basis to support the Quadruple Aim adding the goal of improving the work-life balance of health care providers. Based on testimony, your Reference Committee recognizes that the inclusion of physicians and other providers is meant to provide an accurate reflection of the general terminology of the Quadruple Aim and to recognize that the physician is part of a care team where the health of all members of the physician-led health care team is imperative to its ability to provide quality care. To that end, your Reference Committee proposes a title change to more accurately capture the amendments proposed. Accordingly, your Reference Committee recommends that Resolution 104 be adopted as amended.

(11) RESOLUTION 106 - EDUCATION ABOUT PRE-EXPOSURE
PROPHYLAXIS FOR HIV

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 106 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association ~~continue its efforts to~~ educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 106 be amended by addition and deletion as follows:

~~RESOLVED, That our AMA support the coverage of ~~advocate that all insurers be required to cover the costs associated with the administration of PrEP in all clinically appropriate circumstances.~~ (Directive to Take Action); ~~and be it further~~~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends deletion of the third Resolve of Resolution 106:

~~RESOLVED, That our AMA work with governmental officials to study the feasibility of providing PrEP free of charge to high risk individuals. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 106 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 106 be changed to read as follows:

PRE-EXPOSURE PROPHYLAXIS FOR HIV

HOD ACTION: Resolution 106 adopted as amended.

Resolution 106 asks that our AMA continue its efforts to educate physicians about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines; advocate that all insurers be required to cover the costs associated with the administration of PrEP; and work with governmental officials to study the feasibility of providing PrEP free of charge to high risk individuals.

Testimony on Resolution 106 was generally supportive. There was a suggestion to include the public in education on pre-exposure prophylaxis for HIV (PrEP), and your Reference Committee agrees. Your Reference Committee also proposes an amendment to the first Resolve to reflect that the AMA has not previously been active in the specific area of PrEP education. Your Reference Committee received significant testimony in support of coverage for PrEP but opposing the second Resolve as-written due to AMA policy opposing benefit mandates. Therefore, your Reference Committee suggests a balanced approach of this resolve in support of coverage but in opposition to a benefit mandate. Your Reference Committee received an amendment to include simplifying the prior authorization process of PrEP. Though in agreement with the spirit of this amendment, your Reference Committee notes substantial AMA policy on prior authorization and believes the inclusion of this phrase would detract from the resolution's focus.

Regarding the third Resolve, your Reference Committee received testimony expressing concern over the significant cost of conducting such a study. Further, your Reference Committee is unclear what an AMA study would add to the already wide array of PrEP clinical trials and studies taking place that explore the feasibility and medication adherence of offering PrEP for free (See, e.g., www.avac.org/trial-summary-table/prep). Additionally, your Reference Committee notes that there are already ways to get PrEP at little to no cost including prescription assistance programs, clinical trial participation, Medicaid, and some cities (e.g. San Francisco) now cover the cost of PrEP. Accordingly, your Reference Committee recommends adopting Resolution 106 as amended and offers a title change to reflect amended language.

(12) RESOLUTION 107 - ARBITRARY RELATIVE VALUE DECISIONS BY CMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 107 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association, together with other state medical associations and the national medical specialty societies, work to ensure that the resource-based relative value system and physician work values follow the statutory provisions that require the consideration of time and intensity to change federal law by creating new checks and balances on the Centers for Medicare & Medicaid Services (CMS) regarding the Relative Value Scale and other fee determination methodologies. (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 107 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA, working with state medical associations and national medical specialty societies, strongly advocate that Centers for Medicare and Medicaid Services restore the Refinement Panel to serve as the appeals process that was appropriately in place from 1993-2010. for the development and implementation of an appeal process both within CMS and the courts regarding fee and relative value determinations for specific procedures. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 107 be adopted as amended.

HOD ACTION: Resolution 107 adopted as amended.

Resolution 107 asks that our AMA work with state medical and national specialty societies to change federal law by creating new checks and balances on CMS regarding the Relative Value Scale and other fee determination methodologies, and strongly advocate for the development and implementation of an appeal process both within CMS and the courts regarding fee and relative value determinations for specific procedures.

Your Reference Committee heard testimony voicing several concerns with Resolution 107. Several speakers expressed major concern with involving the judicial system and with seeking legislation. One speaker noted their past experience with filing a lawsuit only to find out that statute (Social Security Act Sec. 1848. [42 U.S.C. 1395w-4] (i) (1) (B)) prohibits judicial review of the determination of relative value units in the resource-based relative value system.

A speaker proposed to amend the first Resolved of Resolution 107 to instead ask that our AMA strongly encourage CMS to take into account both the amount of physician time and level of physician work intensity when determining physician work values for the resource based relative value system, as required by statute in the Social Security Act (Sec. 1848. [42 U.S.C. 1395w-4] (c) (C) (i)). Your Reference Committee heard extensive testimony voicing support for this change, with several speakers noting that recently, CMS has rejected certain recommendations for the AMA/Specialty Society Relative Value Scale Update Committee (RUC) solely based on changes in physician time, without CMS also considering changes in physician intensity.

Many speakers supported the general need for an appeals process within CMS. Several speakers noted that, from 1993 to 2010, the CMS Refinement panel was widely considered such an appeals process. Speakers noted that the CMS Refinement Panel is organized and composed by CMS and consists of members from primary care organizations, contractor medical directors, a specialty related to the commenter and the commenting specialty. Testimony noted that, in 2011, CMS modified the process to only consider codes for which new

clinical information was provided via comment letter. Furthermore, CMS also began independently reviewing each of the Refinement Panel decisions in determining which value to actually finalize. Following these changes, the Refinement Panel ceased to function as a general appeals process. For the 10 years preceding 2011, CMS accepted 100 percent of Refinement Panel recommendations. Following the change in 2011, CMS has accepted only 34 percent of Refinement Panel recommendations.

Testimony strongly supported amending the second Resolve of Resolution 107 to instead ask that our AMA strongly encourage CMS to modify its Refinement Panel process to function as an appeals process, as it previously operated from 1993 through 2010. Your Reference Committee concurs.

Your Reference Committee applauds the sponsor for raising the concern about the need for an effective appeals process for the relative-value scale update system and physician work values. However, the Reference Committee agrees with the extensive testimony noting the CMS Refinement Panel previously served this function prior to 2011. In addition, your Reference Committee agreed with testimony requesting that the AMA strongly recommend for CMS to take into account both the amount of physician time and level of physician work intensity when determining physician work values. Accordingly, your Reference Committee recommends amending Resolution 107 by addition and deletion as indicated.

(13) RESOLUTION 110 - OPPOSING LIMITS ON CARE BASED SOLELY ON ICD-10 CODE SPECIFICITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 110 be amended by deletion as follows:

RESOLVED, That our American Medical Association oppose limitations in coverage for medical services based solely on diagnostic code specificity; ~~especially in cases when it would be less accurate or spurious to use an alternate diagnosis code.~~ (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 110 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 110 be changed to read as follows:

OPPOSING COVERAGE DECISIONS BASED SOLELY ON ICD-10 CODE SPECIFICITY

HOD ACTION: Resolution 110 adopted as amended.

Resolution 110 asks that our AMA oppose limitations in coverage for medical services based solely on diagnostic code specificity, especially in cases when it would be less accurate or spurious to use an alternate diagnosis code.

Your Reference Committee heard supportive testimony on Resolution 110. Several speakers noted that payers are now requiring that claims include the added specificity now available in ICD-10. In certain instances, this added level of specificity is either not available or not clinically appropriate to report.

A speaker recommended the deletion of all text following the word “specificity” on line 30, arguing that the subsequent caveat added little to the resolution and was unnecessary. Several other speakers supported this

amendment by deletion. A speaker also noted that the title of Resolution 110 does not fully align with the content of the resolution and recommended for the word “care” to be replaced with “payment” in the title.

Your Reference Committee believes that the testimony provided speaks to the urgency of this issue. In addition, your Reference Committee concurred that a change in the title of the resolution would be appropriate. Your Reference Committee recommends adoption of Resolution 110 as amended with a change in title.

(14) RESOLUTION 111 - SINGLE PAYER HEALTH CARE STUDY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 111 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association research and analyze the benefits and difficulties of a ~~single payer health care system in the United States~~ variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and international experiences. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 111 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 111 be changed to read as follows:

UPDATED STUDY ON HEALTH CARE PAYMENT MODELS

HOD ACTION: Resolution 111 adopted as amended.

Resolution 111 asks that our AMA research and analyze the benefits and difficulties of a single-payer health care system in the United States with consideration of the impact on economic and health outcomes and on health disparities.

Policies H-165.838, H-165.844, and H-165.888 expressly oppose a single payer system. Instead, Policy D-165.950 supports a market-based approach and states that AMA policy on health system reform emphasizes pluralism and individual ownership of health insurance and supports insurance market reforms necessary to allow free market principles to function. To that end, policy and advocacy efforts have focused on empowering state choice to develop and test models for covering the uninsured and to improve insurance coverage (Policies D-165.942, D-165.966, and D-165.957).

There was substantial and mixed testimony on Resolution 111. Testimony reflected the desire to act in the best interests of patients by improving patient access to care and covering the uninsured. Testimony on this item was generally divided into two categories: those in support of a study on single payer health care reform and those opposed to a study.

Testimony in opposition noted that the AMA has a long and distinguished tradition of advocating for health insurance coverage for all Americans, as well as a commitment to pluralism, freedom of choice, freedom of practice, and universal access for patients. Your Reference Committee further notes significant AMA policy committed to transforming health insurance coverage and health care access while prioritizing individual liberty.

Your Reference Committee received testimony requesting any potential study include a list of criteria. However, your Reference Committee finds this amendment to be potentially prescriptive and to go against the intent of the resolution to study the feasibility of such a system.

Overall your Reference Committee notes a distinction between supporting a single payer system and supporting a study on the issue. Your Reference Committee found testimony by the sponsor to be reasonable and persuasive. Your Reference Committee notes numerous reports by the Council on Medical Service evaluating health care financing payment models and believes it may be timely to reassess a variety of health care financing models, including single payer. Your Reference Committee offers language to this effect and suggests a change in title accordingly. An additional amendment stated that it may be valuable for a study to include evaluation of lessons learned from other countries with varying health care payment models, and your Reference Committee concurs. Accordingly, your Reference Committee recommends that Resolution 111 be adopted as amended.

(15) RESOLUTION 112 - HIERARCHICAL CONDITION CATEGORY CODING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 112 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association continue to work with the Centers for Medicare & Medicaid Services to refine risk adjustment in all alternative payment models and revise the current Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow from one that results in the annual deletion of hierarchical condition category (HCC) codes associated with Medicare Advantage beneficiaries to one that permits past medical and surgical diagnoses to automatically follow the beneficiary from year-to-year to when the HCC codes reflect chronic conditions that will never change be resolved. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 112 be adopted as amended.

HOD ACTION: Resolution 112 adopted as amended.

Resolution 112 asks that our AMA work with CMS to revise the current Medicare Advantage risk-adjustment process from one that results in the annual deletion of hierarchical condition category codes associated with Medicare Advantage beneficiaries to one that permits past medical and surgical diagnoses to automatically follow the beneficiary from year-to-year when the HCC codes reflect chronic conditions that will never be totally resolved.

Your Reference Committee received mixed testimony on Resolution 112. Your Reference Committee notes that HCC codes are a payment methodology based on risk and used by CMS to adjust Medicare Advantage plan payments at the patient level. CMS requires that diagnoses be reestablished each year to ensure that next year's payments will cover the costs of patient care. Testimony noted that this requirement is arbitrary and compounds physician administrative burden where chronic conditions for individual patients must be reestablished each year. Additional testimony noted that comprehensive care reasonably requires reestablishing diagnoses. Testimony by the sponsor clarified that this resolution does not apply to chronic conditions that may change over time but instead to conditions that do not change over time such as an amputation or organ removal. Your Reference Committee anticipates unforeseen circumstances resulting from carrying over all chronic conditions from year-to-year. Your Reference Committee concurs with the sponsor that it is appropriate where conditions do not change and therefore does not find a need to study the process of risk stratification as testimony suggested, which would correspond with a significant fiscal note. As such, your Reference Committee proposes

that this resolution be broadened such that it also applies to desired risk adjustment in alternative payment models and recommends that Resolution 112 be adopted as amended.

(16) RESOLUTION 113 - SUPPORT FOR EQUAL HEALTH CARE ACCESS FOR EATING DISORDERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 113 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association modify Policy H-185.974, Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs, by addition and deletion to read as follows:

Our AMA supports parity of coverage for mental illness, alcoholism, ~~and substance use, and eating disorders, and will advocate against exclusions from coverage of specific diagnoses such as eating disorders.~~ and will (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends deletion of the second Resolve of Resolution 113:

~~RESOLVED, That our AMA advocate that the treatment of eating disorders is specifically included in medical benefits programs. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 113 be adopted as amended.

HOD ACTION: Resolution 113 adopted as amended.

Resolution 113 asks that our AMA modify Policy H-185.974, Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs, by addition and deletion to read as follows:

Our AMA supports parity of coverage for mental illness, alcoholism and substance use, and will advocate against exclusions from coverage of specific diagnoses such as eating disorders.

Resolution 113 also asks that our AMA advocate that the treatment of eating disorders is specifically included in medical benefits programs.

Testimony expressed concern that while eating disorders are mental health conditions and should be covered under mental health parity regulations, necessary health care services for eating disorders have been specifically excluded by some health insurers. A speaker indicated support for the intent of amending Policy H-185.974, but felt that the wording by the sponsor could be clearer and suggested simply adding “and eating disorders,” after “substance use.”

A member of the Council on Medical Service emphasized that the requests in Resolution 113 are addressed by AMA policy on parity of mental health coverage and integration of and payment for physical and behavioral health care services (Policies H-345.975 and H-385.915). However, AMA Policies H-185.964 and H-165.856 caution against benefit mandates which could increase the cost of health insurance. Your Reference Committee believes that amended Policy H-185.974 addresses the intent of both resolves in Resolution 113 and therefore suggests striking the second resolve.

(17) RESOLUTION 114 - PARITY IN RISK-ADJUSTMENT BETWEEN
“NEWLY ASSIGNED” AND “CONTINUOUSLY ASSIGNED” MEDICARE
SHARED SAVINGS PROGRAM BENEFICIARIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 114 be amended by addition and deletion to read as follows:

RESOLVED, That ~~our in concert with~~ American Medical Association continue seeking policy supporting the even application of risk-adjustment in ACO settings, ~~our AMA obtain upward parity in the application of~~ to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned for both “newly assigned” and “continuously assigned” Medicare Shared Savings Program beneficiaries ~~by aggressively advocating to the Centers for Medicare & Medicaid Services and, if need be, the Congress, to attain such parity for patients and physicians and report progress back to this House at the 2017 Annual Meeting.~~ (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 114 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 114 be changed to read as follows:

RISK ADJUSTMENT REFINEMENT IN ACO SETTINGS AND MEDICARE
SHARED SAVINGS PROGRAMS

HOD ACTION: Resolution 114 adopted as amended.

Resolution 114 asks that in concert with AMA policy supporting the even application of risk-adjustment in ACO settings, our AMA obtain upward parity in the application of Hierarchical Condition Category risk scores for both “newly assigned” and “continuously assigned” Medicare Shared Savings Program beneficiaries by aggressively advocating to the Centers for Medicare & Medicaid Services and, if need be, the Congress, to attain such parity for patients and physicians and report progress back to this House at the 2017 Annual Meeting.

Consistent with AMA policy H-160.915, your Reference Committee notes that AMA advocacy efforts have demonstrated continued commitment to risk adjustment refinements, including the specific risk adjustment revision called for in Resolution 114. In a recent letter to CMS, the AMA stated that it continues to oppose CMS’s use of different methods for updating risk adjustment for newly and continuously assigned beneficiaries. The letter acknowledges that CMS’s current policy effectively limits risk adjustment due to demographic factors for all continuously assigned beneficiaries. Further, CMS policy unreasonably assumes that a provider organization, however effective, can manage a population such that patient conditions never worsen over time and never carry a higher disease burden. Therefore, the letter specifically urges that CMS should, within limits, allow risk scores to increase year-over-year within an agreement period for the continuously assigned. Your Reference Committee appreciates these recent efforts and thanks the author for bringing up this important issue. Accordingly, your Reference Committee offers an amendment that both recognizes continued AMA efforts on risk adjustment refinement and recognizes the importance of more targeted AMA policy. To that end, your Reference Committee recommends that Resolution 114 be adopted as amended.

(18) RESOLUTION 120 - REQUIRING SECONDARY AND SUPPLEMENTAL
INSURERS TO MEDICARE TO FOLLOW MEDICARE PAYMENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 120 be adopted as amended by addition and deletion as follows:

RESOLVED, That our American Medical Association support payment by study possible action that would require the secondary and supplemental insurers of to accept in full the balance of the services that are approved and not bundled by Medicare payment. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 120 be adopted as amended.

HOD ACTION: Resolution 120 adopted as amended.

RESOLVED, That our AMA support payment by secondary insurers of the balance of the approved Medicare payment in an amount bringing Medicare and secondary payments up to the full allowance of the secondary insurer for services covered by the secondary insurer.

Resolution 120 asks that our AMA study possible action that would require the secondary and supplemental insurers to accept in full the balance of services that are approved and not bundled by Medicare.

Your Reference Committee received minimal testimony on Resolution 120. An amendment was offered to support the action requested, rather than study the issue, and your Reference Committee accepts this amendment. In light of the suggested policy, your Reference Committee does not recognize a need for further study. Accordingly, your Reference Committee recommends adopting as amended.

(19) RESOLUTION 108 - CONTINUED SURGICAL CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 108 be referred.

HOD ACTION: Resolution 108 referred.

Resolution 108 asks our AMA seek legislation/regulation which would allow a physician who has performed an initial surgical procedure, to continue to follow the patient and perform any necessary follow-up surgery, regardless of the physician's change in participation status; and that any follow-up surgery performed by a physician whose participation status changed after the initial surgery was performed, be reimbursed appropriately based on their current participation status.

Your Reference Committee heard limited testimony in support of Resolution 108. One speaker recommended that the resolution to be broadened to other specialties and services beyond surgery. Your Reference Committee notes that Resolution 108 does not define a length of time or a course of treatment for which it would apply. In addition, your Reference Committee notes that the request to broaden the scope of this resolution seemed appropriate but was difficult to define. Although overall testimony was in general support, your Reference Committee notes that this is an overly complex issue that requires further research and review. Accordingly, your Reference Committee recommends referral of Resolution 108.

(20) RESOLUTION 115 - SURVEY OF ADDICTION TREATMENT CENTERS AVAILABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 115 be referred.

HOD ACTION: Resolution 115 referred.

Resolution 115 asks that our AMA survey practicing physicians about the availability of mental health resources for the treatment of addiction within their local community; specifically address the availability of referrals for a) Medicare patients and b) Medicaid patients c) managed care patients and d) patients with private insurance; and publicly release the results of this study with the intention of helping to remedy the probable shortage of addiction treatment centers, especially for our Medicare and Medicaid patients.

The sponsor of Resolution 115 emphasized the difficulty in finding treatment services for addiction use disorders and the lack of payment for such services. The sponsor requested referral for study, specifically stating that the creation of a resource guide for physicians to locate treatment centers in their community would be beneficial. The American Psychiatric Association proposed that a resource should outline the treatment services that are available in each treatment center. The American Academy of Pediatrics requested that the resource include available services for pediatric and uninsured populations.

(21) RESOLUTION 118 - ADDRESSING THE HEALTH AND HEALTH CARE ACCESS ISSUES OF INCARCERATED INDIVIDUALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 118 be referred.

HOD ACTION: Resolution 118 referred.

Resolution 118 asks that our AMA advocate for an adequate number of health care providers to address the medical and mental health needs of incarcerated individuals; an adequate number of primary care and mental health personnel to provide adequate health care treatment to civilly committed (designated to correctional institutions), incarcerated, or detained individuals; and for the reversal of the “inmate exclusion clause” such that detainees and inmates who are eligible for state and federally funded insurance programs in the community maintain their eligibility when they are pre-trial, detained up to one year, and within one year of release to improve health outcomes in this vulnerable population and decrease its burden of racial and ethnic health care disparities.

Many speakers expressed concern for the incarcerated population and the need for comprehensive health care. A member of the Council on Medical Service indicated that addressing the health and health care access issues of incarcerated individuals fits within the scope of a Council report for I-16 and suggested that Resolution 118 be referred to be considered with the forthcoming Council report. As such, your Reference Committee recommends that Resolution 118 be referred.

(22) RESOLUTION 117 - MULTIDISCIPLINARY PAIN MANAGEMENT CENTER REIMBURSEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-185.931, D-160.981, and H-70.919 be reaffirmed in lieu of Resolution 117.

HOD ACTION: Policies H-185.931, D-160.981, and H-70.919 reaffirmed in lieu of Resolution 117.

Resolution 117 asks that our AMA consider alternative payment models for the reimbursement of services supplied by multidisciplinary pain management centers. The services would need to include pain physicians, physical

therapists, psychologists and psychiatrists at a minimum; consider bundled payments, global fees or other alternatives payment models for reimbursement to multidisciplinary pain management centers; and that interested stakeholders consider whether additional CPT codes are required for a multidisciplinary pain management center's reimbursement.

Your Reference Committee received mixed testimony on Resolution 117. A member of the Council on Medical Service testified that the recent joint Council on Medical Service and Council on Science and Public Health Report 1-A-15 established Policy H-185.931 directing the AMA to advocate for increased focus on comprehensive, multidisciplinary pain management approaches and to support health insurance coverage that gives patients the full range of evidence-based chronic pain management modalities. Further, a member of the Council testified that CMS Report 9-A-16, currently being considered by the House, recommends supporting the development of alternative payment models (APMs) by medical societies and other physician organizations recognizing that specialties are best poised to identify and develop APMs that suit their specific specialty. The AMA has been instrumental in fostering the development of APMs by establishing workgroups with state medical societies and specialty societies, organizing CMS listening sessions with representatives of national medical organizations and state medical societies, and meeting regularly with key CMS officials and staff to keep Congress apprised of regulatory developments, among other activities. These actions have promoted information sharing and provided support to specialty societies to develop the APMs best suited for their unique practice environments. In light of this policy, your Reference Committee finds no need to adopt nor to study the first or second Resolve clauses.

Regarding the third Resolve, a member of the CPT Editorial Panel testified that the appropriate mechanism for considering the addition of CPT codes is described in current Policy H-70.919, "Use of the CPT Editorial Panel Process," which establishes the independent CPT Editorial Panel process as the proper mechanism for addressing issues of this nature. Anyone desiring an addition to the CPT code set must submit an application to the independent CPT Editorial Panel. The application must be completed in accordance with established deadlines and procedures, which are outlined on our AMA web site. This is the only pathway for achieving a change to the CPT code set, and your Reference Committee therefore does not recognize the need for the third Resolve.

Additionally, your Reference Committee notes the importance of Policy D-160.981 expressing the AMA's strong commitment to better access and delivery of quality pain care. Accordingly, your Reference Committee concurs with the Committee on Rules and Credentials in recommending reaffirmation of Policies H-185.931, D-160.981, and H-70.919 in lieu of Resolution 117.

H-185.931, Coverage for Chronic Pain Management

1. Our American Medical Association will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
2. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
3. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process. (CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15)

D-160.981, Promotion of Better Pain Care

Our AMA: (1) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; (2) encourages relevant specialties to collaborate in studying the following: (a) the scope of practice and body of knowledge encompassed by the field of pain medicine; (b) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (c) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (d) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic; and (3) will participate in the International Association for the Study of Pain (IASP) International Pain Summit to be held in Montreal, Canada, on September 3, 2010; and encourages the participation of affiliate pain specialty societies, the American Board of Medical Specialties, the

Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and other relevant organizations in the IASP Pain Summit. (Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12)

H-70.919, Use of CPT Editorial Panel Process

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers. (BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-11; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, I-15)

(23) RESOLUTION 121 - ASSESSMENT OF THE IMPACT OF HIGH DEDUCTIBLE HEALTH PLANS ON PATIENT HEALTH AND THE FINANCIAL IMPACT ON MEDICAL PRACTICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-165.828, D-155.987, H-155.960 and H-185.939 be reaffirmed in lieu of Resolution 121.

HOD ACTION: Policies H-165.828, D-155.987, H-155.960 and H-185.939 reaffirmed in lieu of Resolution 121.

Resolution 121 asks that our AMA advocate for uniform (minimum) standards for improving patient education and policies regarding deductibles for preventive care and essential preventive and diagnostic services in high deductible health plans (HDHPs); study the effects of HDHPs on the access to care among patients; work with key stakeholders, such as local and national medical and specialty organizations, medical schools, and practicing physicians to develop Clinical Care Pathways to establish standards for common clinical conditions, and that our AMA further develop a classification system of HDHPs based on the risk incurred by the (1) patients and (2) providers; advocate for systems that will improve health cost transparency including “real time” assessment of cost for HDHPs, and the status of patient’s deductibles at the point of service; and establish payment models for HDHPs, which will improve both patient compliance with necessary medical care and the ability of providers to collect health care plan deductibles and other out-of-pocket expenses, such that the viability of health care systems in medically underserved communities can be assured.

Mixed testimony was heard on Resolution 121. The sponsors indicated that the intent of bringing forth this resolution stems from concerns that there are unintended consequences of HDHPs, such as costs of medical insurance being shifted to patients. As a result, physician practices are in financial jeopardy when patients cannot afford to cover the costs of their care. In addition, physicians are at risk of being held responsible for the poor health outcomes of patients who forego health care treatments until absolutely necessary and then need more expensive health care services when they do seek care.

The Council on Medical Service testified that the majority of the requests in Resolution 121 are already addressed by AMA Policy that the Council has developed in previous reports, such as on educating patients on the costs of health care, the impact of affordability on access to care, increased price transparency, and the use of targeted benefit design and value-based benefit design. The Council will continue to monitor these issues.

Policies H-165.828 and D-155.987 encourage efforts to educate patients in health economics literacy, including information on the cost of deductibles and cost-sharing at the time an individual enrolls in a health plan. Policy H-165.828 acknowledges the impact that health insurance affordability has on access to care and outlines strategies to ameliorate financial barriers to care for individuals with HDHPs, including support for demonstrations that allow high deductible bronze plan enrollees to have access to partially funded HSAs. Policy D-155.987 advocates for increased price transparency when individuals are enrolling in a health care plan and at the point of service. Policy H-155.960 encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment and Policy H-185.939 emphasizes

that value-based insurance design programs must explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing structures.

Testimony from a member of the Board of Trustees emphasized that the request in the third resolve of Resolution 121 for the AMA to develop clinical care pathways (CCP) is not within the AMA's purview. The closest activity the AMA engages in is the AMA's Improving Health Outcomes strategic focus area, which provides physicians with tools to address hypertension and prediabetes in their patients. Of importance, the resolution's estimated fiscal note of \$200,000 would most likely barely cover the cost of developing, testing, disseminating and implementing just one CCP. The AMA believes that the development of CCPs is something best accomplished by specialties with the necessary clinical expertise. Several other speakers agreed to strike the recommendation for the AMA to develop CCPs and your Reference Committee agrees. Your Reference Committee believes that existing AMA policy addresses the requests in Resolution 121 and recommends reaffirmation of Policies H-165.828, D-155.987, H-155.960 and H-185.939.

H-165.828 Health Insurance Affordability 1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA). 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy. 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible. 5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. 6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA. (CMS Rep. 8, I-15)

D-155.987 Price Transparency 1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible. 2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs. 3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide. 4. Our AMA will work with states to support and strengthen the development of all-payer claims databases. 5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients. 6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving. 7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments. (CMS Rep. 4, A-15)

H-155.960 Strategies to Address Rising Health Care Costs. Our AMA:(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote "value-based decision-making" at all levels; (3) will continue to advocate that physicians

be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training; (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers; (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings; (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system. (CMS Rep. 8, A-07; Reaffirmed in lieu of Res. 122, A-15)

H-185.939 Value-Based Insurance Design. Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles: a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements. b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists. c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan. d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients. e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design. f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties. h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence. i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972). (CMS Rep. 2, A-13 Reaffirmed in lieu of Res. 122, A-15)

REPORT OF REFERENCE COMMITTEE B

- (1) BOARD OF TRUSTEES REPORT 10 - ELECTRONIC HEALTH RECORDS AND MEANINGFUL USE; PARTIAL CREDIT FOR ELIGIBLE PROFESSIONALS; AND REPEAL COMPULSORY ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 10 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 10 adopted.

The Board of Trustees Report 10 recommends that the following be adopted in lieu of Resolutions 224-A-15, 227-A-15, and 228-A-15, and Substitute Resolution 224-A-15 and the remainder of the report be filed: That our American Medical Association continue to work with the Centers for Medicare & Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs. (New HOD Policy); and that our AMA compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions. (Directive to Take Action)

Your Reference Committee heard unanimous support of Board of Trustees Report 10. Testimony highlighted that the MACRA proposed rule incorporates ongoing advocacy efforts by our AMA to remove the pass-fail approach of the MU program. In addition, testimony agreed that physicians need more education about how to secure and protect the information in their EHRs. Your Reference Committee strongly believes that these efforts are important and therefore recommends that the recommendations of Board of Trustees Report 10 be adopted and that the remainder of the report be filed.

- (2) BOARD OF TRUSTEES REPORT 11 - PRINCIPLES FOR HOSPITAL-SPONSORED ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

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

HOD ACTION: Board of Trustees Report 11 adopted.

Board of Trustees Report 11 recommends that the additional recommendations to Board of Trustees Report 1-I-15 not be adopted and the remainder of the report be filed.

Your Reference Committee heard supportive testimony on Board of Trustees Report 11. Testimony noted that there are potential problems with adopting new AMA policy that defines physicians as custodians of patient data. Specifically, those testifying agreed that the term “custodian” could convey a sense of legal obligation related to the security of the data. The term could also confuse stakeholders that we are impinging on the rights of patients to access and manage their data. Therefore, your Reference Committee recommends that the recommendation of Board of Trustees Report 11 be adopted and that the remainder of the report be filed.

- (3) BOARD OF TRUSTEES REPORT 13 - RESTRICTIVE COVENANTS IN PHYSICIAN CONTRACTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation of Board of Trustees Report 13 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 13 adopted.

Board of Trustees Report 13 recommends that the following recommendation be adopted in lieu of Resolution 203-A-15 and that the remainder of the report be filed: That our American Medical Association provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies. (New HOD Policy)

Your Reference Committee heard unanimous support for this report and therefore recommends that the recommendation of Board of Trustees Report 13 be adopted and that the remainder of the report be filed.

(4) BOARD OF TRUSTEES REPORT 27 - NOMINATION FOR AND IMPROVEMENT OF THE POSITION OF THE UNITED STATES SURGEON GENERAL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation of Board of Trustees Report 27 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 27 adopted.

Board of Trustees Report 27 recommends that our AMA convey to the Presidential Transition Team support for an enhanced role for the Surgeon General in addressing important matters of public health. (Directive to Take Action)

Your Reference Committee heard unanimous support for this report and therefore recommends that Board of Trustees Report 27 be adopted.

(5) RESOLUTION 202 - SUPPORTING LEGISLATION TO CREATE STUDENT LOAN SAVINGS ACCOUNTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 202 be adopted.

HOD ACTION: Resolution 202 adopted.

Resolution 202 asks that our American Medical Association advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans. (New HOD Policy)

Your Reference Committee heard strong support for Resolution 202. Your Reference Committee strongly believes that it is essential to provide as many avenues as possible to facilitate repayment of student debt. Therefore, your Reference Committee recommends that Resolution 202 be adopted.

(6) RESOLUTION 203 - OPPOSITION TO DISCLOSURE OF DRUG USE AND ADDICTION TREATMENT HISTORY IN PUBLIC ASSISTANCE PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 203 be adopted.

HOD ACTION: Resolution 203 adopted.

Resolution 203 asks that our American Medical Association amend Policy H-270.966 by addition and deletion as follows (Modify Current HOD Policy): H-270.966 Disclosure of Drug Use and Addiction Treatment History in Public Housing Applications Assistance Programs. The AMA opposes ~~Section 301 d (the Grams Amendment of the Public Housing Reform and Responsibility Act of 1997), which authorizes public housing agencies to require a) requiring~~ that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance, ~~and seeks its removal and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, “welfare”) and/or the Supplemental Nutrition Assistance Program (SNAP, “food stamps”) to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.~~

Your Reference Committee heard general support for Resolution 203, with limited testimony in favor of referral. Your Reference Committee heard testimony supporting extending Policy H-270.966 to apply beyond housing to food and other public assistance. Your Reference Committee also notes that the proffered amendment accomplishes these goals while simply deleting reference to a specific program. Your Reference Committee commends the authors for bringing forward this important issue and therefore recommends that Resolution 203 be adopted.

(7) RESOLUTION 210 - STATUE OF LIMITATIONS FOR MEDICARE AND RAC “LOOKBACKS”

RECOMMENDATION:

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

HOD ACTION: Resolution 210 adopted.

Resolution 210 asks that our American Medical Association work with Medicare to reduce the “Lookback” period to be no longer than the length of time allowed to submit a claim for consideration. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 210. Your Reference Committee agrees that “look back” period for Medicare and Recovery Audit Contractor (RAC) audits can be extremely burdensome and unfair to practicing physicians. Because Resolution 210 is consistent with existing AMA policy, your Reference Committee recommends that Resolution 210 be adopted.

(8) RESOLUTION 211 - CMS REVALIDATION OF MEDICARE BILLING PRIVILEGES

RECOMMENDATION:

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

HOD ACTION: Resolution 211 adopted.

Resolution 211 asks that That our American Medical Association advocate for the Centers for Medicare & Medicaid Services (CMS) to adopt the practice of sending revalidation notices to physicians using certified mail with return receipt, thus ensuring that such notices are actually sent by CMS and received by the physician. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 211. Your Reference Committee understands and acknowledges the negative repercussions to physician practices resulting from delayed Medicare revalidation. Therefore, your Reference Committee recommends that Resolution 211 be adopted.

(9) RESOLUTION 215 - TAX EXEMPTIONS FOR FEMININE HYGIENE PRODUCTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 215 be adopted.

HOD ACTION: Resolution 215 adopted.

Resolution 215 asks that our American Medical Association support legislation to remove all sales tax on feminine hygiene products. (New HOD Policy)

Your Reference Committee heard testimony in support of Resolution 215. Your Reference Committee acknowledges that there is significant movement in the states to adopt sales tax exemptions for feminine hygiene products and that a number of states have already adopted this type of legislation. Due to the nearly unanimous testimony in support of this resolution, your Reference Committee recommends that Resolution 215 be adopted.

(10) RESOLUTION 219 - DRY NEEDLING BY PHYSICIAN THERAPISTS AND OTHER NON-PHYSICIAN PROVIDERS
RESOLUTION 223 - DRY NEEDLING IS AN INVASIVE PROCEDURE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 223 be adopted in lieu of Resolution 219.

HOD ACTION: Resolution 223 adopted in lieu of Resolution 219.

Resolution 219 asks that our American Medical Association develop policy on the issue of dry needling practice by non-physician groups including physical therapists, in order to guide this conversation at the national level (New HOD Policy); and that AMA policy on the practice of dry needling by physical therapists and other non-physician groups include, at a minimum, the benchmarking of training standards to already existing standards of training, certification, and continuing education that exist for the practice of acupuncture (New HOD Policy). Resolution 223 asks that our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolutions 219 and 223. Your Reference Committee strongly believes that our AMA should advocate against inappropriate scope of practice expansions, including the expansion of physical therapy into acupuncture or dry needling. Your Reference Committee heard testimony cautioning that characterizing dry needling as an invasive procedure may not be consistent with AMA policy on surgery and may have the unintended consequence of limiting acupuncture and dry needling to being performed by physicians only. However, your Reference Committee believes that Resolution 223 makes clear that dry needling, due to risks, should be performed only by physicians and licensed acupuncturists. Your Reference Committee also believes that Resolution 223, as acknowledged by the author of Resolution 219, accomplishes the goal of Resolution 219. Therefore, your Reference Committee recommends that Resolution 223 be adopted in lieu of Resolution 219.

(11) RESOLUTION 222 - EXPEDITED REVIEW FOR CLERICAL ERRORS ON MEDICARE ENROLLMENT APPLICATIONS

RECOMMENDATION:

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

HOD ACTION: Resolution 222 adopted.

Resolution 222 asks that our American Medical Association urge the Centers for Medicare & Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges (Directive to Take Action); that our AMA urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake (Directive to Take Action); and that our AMA urge CMS to create a process that not only reactivates a physician's billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame (Directive to Take Action).

Your Reference Committee heard limited testimony supportive of Resolution 222. A member of the Council on Legislation testified to our AMA's support for preventing delays in Medicare enrollment and revalidation due to minor clerical errors and differentiating inadvertent mistakes from legitimate fraud and abuse inquiries. The Council noted that CMS recently released a proposed rule on Program Integrity Enhancements to the Provider Enrollment Process and that our AMA is currently partnering with numerous specialty societies to address concerns that certain provisions in the proposed rule would significantly increase regulatory burden without efficiently targeting enforcement toward actionable fraud. Your Reference Committee also notes that this resolution is consistent with but not duplicative of existing AMA policy regarding delays in Medicare enrollment and overzealous application of fraud and abuse regulations. Therefore, your Reference Committee recommends adoption of Resolution 222.

(12) RESOLUTION 233 - INSURANCE COVERAGE PARITY FOR
TELEMEDICINE SERVICE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 233 be adopted.

HOD ACTION: Resolution 233 adopted.

Resolution 233 asks that our American Medical Association advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers (New HOD Policy); that our AMA develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies (Directive to Take Action); and that our AMA work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board (Directive to Take Action).

Your Reference Committee heard that our AMA already has developed model state legislation that accomplishes the goals of this resolution, and is already advocating at the state level in collaboration with state medical associations, consistent with this resolution, and with considerable success. In particular, the model AMA Telemedicine Act advocates for telemedicine coverage parity, ensures that physicians who practice telemedicine are licensed in the state where the patient is located, must abide by the laws and regulations of the state where the patient is located, and are subject to the jurisdiction of the medical board of the state where the patient is located. Your Reference Committee also heard that our AMA is already collaborating with interested stakeholders to pursue state legislation and regulation consistent with AMA policy and this resolution, and is interested in working with any state that wishes to pursue telemedicine legislation or regulation in the future.

Your Reference Committee heard strong testimony concerned with the practice of private insurers that cover only telemedicine provided by third-party vendors while denying coverage for telemedicine services provided by physicians treating their existing patients. Your Reference Committee agrees with testimony stating that lack of private insurance reimbursement for telemedicine remains the primary obstacle to widespread adoption of telemedicine within physician practices. While your Reference Committee concluded that Resolution 233 is

consistent with existing AMA policy, adoption of Resolution 233 would further enhance our collaborative advocacy efforts with state medical societies as well as the FSMB. For these reasons, your Reference Committee recommends that Resolution 233 be adopted.

(13) RESOLUTION 236 - REMOVE PAIN SCORES FROM QUALITY METRICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 236 be adopted.

HOD ACTION: Resolution 236 adopted.

Resolution 236 asks our American Medical Association work with the Centers for Medicare & Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five star rating system for nursing facilities. (Directive to Take Action)

Your Reference Committee heard overwhelming support for Resolution 236. Your Reference Committee believes that linking patient satisfaction scores relating to the evaluation and management of pain to physician compensation is inappropriate and may provide an incentive to overprescribe opioid medications. Your Reference Committee further believes that this resolution is consistent with existing AMA policy that supports delinking pain survey question results from being considered as part of hospital and physician reimbursement, and accordingly your Reference Committee recommends that Resolution 236 be adopted.

(14) RESOLUTION 238 - PART B DRUG PAYMENT DEMONSTRATION
RESOLUTION 241 - OPPOSITION TO THE CMS MEDICARE PART B
DRUG PAYMENT MODEL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 241 be adopted in lieu of Resolution 238.

HOD ACTION: Resolution 241 adopted in lieu of Resolution 238.

Resolution 238 asks that, in the event that the Part B drug payment demonstration proposed by the Centers for Medicare and Medicaid Services (CMS) on March 8, 2016, is not withdrawn, our American Medical Association work with CMS to ensure that significant modifications are addressed in any final rule issued for the demonstration, including but not limited to the following principles: CMS must evaluate changes to the Part B program in a much smaller demonstration program evaluating a) availability of high quality and affordable services; b) availability of equivalent alternative therapeutic products with price differentials; c) average total per-patient Medicare costs by drug, as well as average per-beneficiary costs; and d) phasing-in of changes to allow adjustment of operations to ensure that beneficiaries' access to care is not disrupted; and that CMS must align or consider MACRA timeframes and changes and the impact of these changes; and that CMS must establish key exemptions to protect the most vulnerable Medicare- covered entities: a) physician groups of 25 or fewer professionals; b) physician-owned practices located in rural and medically underserved areas; c) drugs and biologics that have no alternatives with more than a 20% ASP differential; d) drugs and biologics where there are 3 or fewer members of the drug and biologic class and similar treatment efficacy; and e) a class of drugs and biologics in which at least one treatment option must be compounded or repackaged or is used off-label (Directive to Take Action); and that, if CMS does not respond to stakeholder input and withdraw or significantly modify the Part B drug payment demonstration according to these and other principles in any final rule that is issued, our AMA support and actively work to advance Congressional action to block the demonstration through legislation or restriction of funding. (Directive to Take Action)

Resolution 241 asks that our American Medical Association request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model (Directive to Take Action); that our AMA support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if

CMS proceeds with the proposal (Directive to Take Action); that our AMA advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients (Directive to Take Action); and that our AMA advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement (Directive to Take Action).

Your Reference Committee heard testimony strongly in support of both Resolution 238 and Resolution 241. Testimony indicated that our AMA is already engaged in vigorous efforts to oppose and rescind the Part B Drug Payment Demonstration Project, and your Reference Committee believes our AMA will continue to advocate that CMS should rescind the controversial Part B drug model. While testimony supported both resolutions, some testimony favored adoption of Resolution 241 in lieu of Resolution 238, on the grounds that Resolution 241 was less prescriptive than Resolution 238. In addition, Resolution 241 provides clear direction and needed flexibility to advance a range of alternatives to the proposed Part B drug model—alternatives which could include measures called for by Resolution 238. Accordingly, your Reference Committee recommends adoption of Resolution 241 in lieu of Resolution 238.

(15) RESOLUTION 239 - OPPOSITION TO THE DEPARTMENT OF VETERANS AFFAIRS PROPOSED RULEMAKING ON APRN PRACTICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 239 be adopted.

HOD ACTION: Resolution 239 adopted.

Resolution 239 asks that our American Medical Association express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented (Directive to Take Action); that our AMA staff assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same (Directive to Take Action); that our AMA call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of Advanced Practice Registered Nurses (APRNs), and comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period (Directive to Take Action); that our AMA collaborate with other medical professional organizations to vigorously oppose the final adoption of the VA's proposed rulemaking expanding the role of Advanced Practice Registered Nurses (APRNs) within the VA. (Directive to Take Action)

Your Reference Committee heard strong and overwhelming testimony in support of Resolution 239. In particular, your Reference Committee heard testimony expressing concern that the VA's proposal, if adopted, would significantly jeopardize state medical associations' chances of success in fighting similar proposals at the state level. The Reference Committee received a wealth of testimony describing the significant disparity in the education and training between physicians and APRNs. Your Reference Committee also heard testimony from the VA that it is currently accepting and reviewing comments on this proposal.

Your Reference Committee also heard that our AMA has been actively engaged in fighting this proposal, while supporting reforms that would simplify the Veterans Choice Program and provide veterans with the care they deserve. Your Reference Committee also heard testimony stating that our AMA will submit comments to the VA on its proposal. Your Reference Committee supports these ongoing efforts and encourages the Federation of Medicine to provide comment on this proposal as well to ensure that our nation's veterans enjoy the benefit of collaborative, physician-led health care teams. For all of the above reasons, your Reference Committee recommends that Resolution 239 be adopted.

(16) RESOLUTION 243 - PRESERVING PATIENT ACCESS TO SMALL PRACTICE UNDER MACRA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 243 be adopted.

HOD ACTION: Resolution 243 adopted.

Resolution 243 asks that our AMA urge CMS to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs (Directive to Take Action); that our AMA advocate for additional exemptions or flexibilities for physicians who practice in Health Professional Shortage Areas (Directive to Take Action); and that our AMA determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 243. Those testifying referenced an impact table in the proposed MIPS rule that suggested small practices could be unfairly penalized by the program. Additional testimony noted that there are substantial flaws in the methodology used to create that table, and that our AMA is actively working to comment on the proposed rule to offer improvements, especially for small and other vulnerable practices. Your Reference Committee recognizes that our AMA is in the process of responding to the proposed rule and that CMS has not finalized any part of the MIPS program. We agree, however, with the testimony heard that additional accommodations should be implemented by CMS to assist small practices. Your Reference Committee also received testimony concerning private contracting, and notes that our AMA has existing policy directly addressing that issue, e.g., Medicare Private Contracting H-385.961, which states that our AMA will “(1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries’ freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective.” Therefore, your Reference Committee recommends adoption of Resolution 243.

(17) BOARD OF TRUSTEES REPORT 06 - COUNCIL ON LEGISLATION SUNSET REVIEW OF 2006 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation of Board of Trustees Report 6 be amended by addition to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, except for Policy D-305.972, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

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

HOD ACTION: Board of Trustees Report 6 adopted as amended.

Board of Trustees Report 06 recommends that that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard and agreed with testimony urging that Policy D-305.972 be retained. Your Reference Committee also heard testimony encouraging that Policies H-100.9972, H-100.982, and D-100.981 be revised and combined into a single policy. Your Reference Committee felt that a sunset report is not an appropriate vehicle through which to amend current policy, and recommends that the concerns raised be brought as a new resolution at a future meeting. Therefore, your Reference Committee recommends that the recommendation of Board of Trustees Report 6 be adopted as amended and that the remainder of the report be filed.

(18) BOARD OF TRUSTEES REPORT 12 - REDUCING GUN VIOLENCE

RECOMMENDATION A:

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

H-145.996 Handgun Availability

The AMA (1) Advocates a waiting period and background check for all firearm purchases ~~purchasers handgun purchasers~~; encourages legislation that enforces a waiting period and background check for all firearm purchases ~~purchasers handgun purchasers~~; and urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

RECOMMENDATION B:

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

HOD ACTION: Board of Trustees Report 12 adopted as amended with a change to policy title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Policy H-145.996 be changed to read as follows:

FIREARM AVAILABILITY

Board of Trustees Report 12 recommends that policy H-145.996 be amended by addition and deletion to read as follows in lieu of Substitute Recommendation, BOT Report 7-A-14, Substitute Resolution 215-A-14 and Resolutions 215-A-14 and 224-A-14, and that the remainder of this report be filed. H-145.996 Handgun Availability. The AMA advocates a waiting period and background check for all firearm purchases ~~handgun purchasers~~; encourages legislation that enforces a waiting period and background check for all firearm purchases ~~handgun purchasers~~; and urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

Your Reference Committee heard testimony generally in support of Board of Trustees Report 12. Testimony from those in favor of adoption noted that firearm mortality and morbidity continues to increase and remains a major public health problem. A representative from the Board of Trustees testified that adoption of the recommendation in this report builds upon existing AMA policy to promote firearm safety and reducing and preventing firearm violence, and would be a logical extension of existing AMA policy that already supports background checks for all purchasers of handguns, and that this is the second year that this Report has been before the HOD. Testimony also

noted that adopting such recommendation would be consistent with recent action taken by the American Psychiatric Association, which adopted a new policy statement that in part calls for requiring background checks (and waiting periods) on all gun sales or transactions, as well as with a call to action on firearm-related injury and death in the U.S. issued in 2014 by eight medical organizations—including the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics—and the American Bar Association. However, testimony opposing adoption was presented that the recommendation was too broad and could extend to transfers of firearms, including antiques, to family members, or individuals who already possess the requisite clearance. Your Reference Committee notes that the Board of Trustees included discussion of these issues in the body of its report.

Your Reference Committee also agrees with online testimony suggesting that the proffered amendments were intended to address “firearm purchasers,” not “firearm purchases.” Your Reference Committee, having heard diverse perspectives on this matter, and hearing strong support of the proffered amendment to Policy H-145.996, recommends that the recommendation of Board of Trustees Report 12 be adopted as amended and that the remainder of the report be filed.

(19) BOARD OF TRUSTEES REPORT 19 - PAIN AS THE FIFTH VITAL SIGN
RESOLUTION 217 - PAIN AS THE FIFTH VITAL SIGN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 19 be amended by addition of a new Recommendation to read as follows:

That our AMA advocate that pain as the fifth vital sign be eliminated from professional standards and usage. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 19 be amended by addition of a new Recommendation to read as follows:

That our AMA advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Madame Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 19 be adopted as amended in lieu of Resolution 217, and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 19 adopted as amended in lieu of Resolution 217.

The Board of Trustees Report 19 recommends that the following be adopted in lieu of Resolution 707-A-15, and that the remainder of the report be filed: that our AMA work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards (New HOD Policy); that our AMA reaffirm D-160.981, “Promotion of Better Pain Care,” H-185.931, “Coverage for Chronic Pain Management,” and D-120.971, “Promoting Pain Relief and Preventing Abuse of Controlled Substances” (Reaffirm HOD Policy); and that our AMA strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient’s access to care (New HOD Policy). Resolution 217 asks that our American Medical Association advocate that pain as the fifth vital sign be eliminated from professional standards and usage. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 217 and the recommendations in Board Report 19. Testimony emphasized the importance of evaluating and treating pain, but suggested that pain should not be used as a metric for quality or other measures. Testimony from the Veterans Health Administration (VHA) also noted that the VHA no longer uses pain as the fifth vital sign, and that the VHA would welcome working with our AMA on pain issues including the study of non-pharmacologic treatment of pain.

Your Reference Committee believes that Board Report 19 cogently provides the background and context for pain as the fifth vital sign, and summarizes current AMA activities in the areas of pain management and addressing the opioid epidemic. Your Reference Committee agrees that Resolution 217 should be adopted, and recommends that the recommendation in Resolution 217 be added as an additional recommendation to Board Report 19. For these reasons, your Reference Committee recommends that the recommendations of Board of Trustees Report 19 be adopted as amended in lieu of Resolution 217, and that the remainder of the report be filed.

(20) BOARD OF TRUSTEES REPORT 22 - STUDY OTC AVAILABILITY OF NALOXONE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendations of Board of Trustees Report 22 be amended by addition of a new Recommendation to read as follows:

That our American Medical Association support efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively. (New AMA Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 22 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 22 adopted as amended with a change in title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Board of Trustees Report 22 be changed to read as follows:

INCREASING AVAILABILITY OF NALOXONE

Board of Trustees Report 22 recommends that the following be adopted in lieu of Resolution 909-I-15, and that the remainder of the report be filed: That our American Medical Association reaffirm Policy D-95.987, "Prevention of Opioid Overdose" (Reaffirm HOD Policy); that our AMA support legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery (New HOD Policy); that our AMA support efforts that enable law enforcement agencies to carry and administer naloxone (New HOD Policy); that our AMA encourage physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients (New HOD Policy); that our AMA encourage private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing (New HOD Policy); and that our AMA support liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law (New HOD Policy).

Your Reference Committee heard testimony in support of increasing access to naloxone. Your Reference Committee also heard testimony in support of Good Samaritan protections for bystanders who call for emergency assistance in a suspected overdose situation. In response, your Council on Legislation testified that Policy D-95.977 already supports Good Samaritan protections, and that your Council on Legislation has already approved model state legislation that would provide such protections. Your Reference Committee heard that our AMA Advocacy Resource Center stands ready to assist any state medical association interested in introducing this model legislation.

Your Reference Committee agrees with testimony in support of an additional resolve supporting AMA advocacy that encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively. Finally, your Reference Committee recommends a title change to more accurately reflect this report's recommendations. Therefore, your Reference Committee recommends that the recommendations of Board of Trustees Report 22 be adopted as amended.

(21) RESOLUTION 204 - USP COMPOUNDING RULES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA undertake to form a coalition with affected physician specialty organizations such as allergy, dermatology, immunology, otolaryngology, oncology, ophthalmology, ~~and~~ neurology, and rheumatology to jointly engage with USP, FDA and the U.S. Congress on the issue of physician office-based compounding preparations and the proposed changes to USP Chapter 797 (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 204 be adopted as amended.

HOD ACTION: Resolution 204 adopted as amended.

Resolution 204 asks that our American Medical Association reaffirm Policies H-120.934 and D-120.949 (Reaffirm HOD Policy); that our AMA engage in efforts to convince United States Pharmacopeia (USP) to retain the current special rules for procedures in the medical office that could include but not be limited to allergen extract compounding in the medical office setting and, if necessary, engage with the U.S. Food and Drug Administration (FDA) and work with the U.S. Congress to ensure that small volume physician office-based compounding is preserved (Directive to Take Action); that our AMA undertake to form a coalition with affected physician specialty organizations such as allergy, dermatology, otolaryngology, oncology, ophthalmology, and neurology to jointly engage with USP, FDA and the U.S. Congress on the issue of physician office-based compounding and the proposed changes to USP Chapter 797 (Directive to Take Action); that our AMA reaffirm that the regulation of compounding in the physician office for the physician's patients be under the purview of state medical boards and not state pharmacy boards (Reaffirm HOD Policy); and that our AMA support the current 2008 USP Chapter 797 sterile compounding rules as they apply to allergen extracts, including specifically requirements related to the beyond use dates of compounded allergen extract stock (New HOD Policy).

Your Reference Committee heard testimony in support of Resolution 204. Your Reference Committee strongly believes that oversight of a physician's medical practice should remain the purview of state medical boards, not state pharmacy boards. The Committee also heard compelling testimony that there is an urgent need for physician organizations to collaborate and coordinate efforts to ensure that patients continue to have access to safe and medically necessary treatments that are prepared and administered by their treating physician. However, the Reference Committee also heard testimony concerning the complexity of the issue, the need to craft nuanced descriptions of the services rendered by physicians who are preparing and administering medication in-office to their patients to ensure that our AMA's policy clearly delineates the medical services physicians are rendering, the scope of state medical board oversight while maintaining access to safe, medical treatment.

Your Reference Committee agreed with testimony recommending that immunology and rheumatology be added to the third resolved. Your Reference Committee also appreciated testimony from US Pharmacopeia (USP) on the public and transparent process, noting that the revisions of Chapter 797 will not go into effect until all comments have been reviewed, and for encouraging stakeholders to submit comments to USP. Your Reference Committee also strongly urges HOD members and their respective organizations to submit comments to USP. Therefore, your Reference Committee recommends that Resolution 204 be adopted as amended.

(22) RESOLUTION 205 - AMA SUPPORT FOR JUSTICE REINVESTMENT INITIATIVES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 205 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support justice reinvestment initiatives ~~legislation~~ aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, ~~streamlining case processing~~ and increasing access to reentry and treatment programs. (New HOD Policy).

RECOMMENDATION B:

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

HOD ACTION: Resolution 205 adopted as amended.

Resolution 205 asks that That our American Medical Association support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 205. While your Reference Committee agrees with the goals of this resolution, your Reference Committee believes that, as drafted, the resolution is too broad and calls on our AMA to support legislation aimed at, among other issues, streamlining case processing, which your Reference Committee thinks is beyond the scope of our AMA's strategic focus and resources. Therefore, your Reference Committee recommends amending the resolution to remove the reference to streamlining case processing and to legislation, and to amend the resolution to call on our AMA to support "justice reinvestment initiatives" and to clarify the reference to improving risk assessment tools. Therefore, your Reference Committee recommends that Resolution 205 be adopted as amended.

(23) RESOLUTION 206 - MINIMIZE PROVIDER BURDEN FOR MEANINGFUL USE AUDIT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate against the "zero tolerance" policy of the current "Meaningful Use" audit program and any similar programs proposed by the Centers for Medicare and Medicaid Services, whereby physicians lose their total incentive payment rather than receive a payment proportional to their ~~success measures~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

Resolution 206 asks that our American Medical Association advocate for all audit programs to have a “look back period” of no more than two years (Directive to Take Action); that our AMA advocate against the “zero tolerance” policy of the current “Meaningful Use” audit program, whereby physicians lose their total incentive payment rather than a payment proportional to the failed measures (Directive to Take Action); and that our AMA advocate to reform the Centers for Medicare & Medicaid Services “Meaningful Use” audit program (Directive to Take Action).

Your Reference Committee heard limited testimony on Resolution 206. Testimony from our AMA’s Council on Legislation noted that the Meaningful Use program is being replaced under the MIPS system, and that the issues raised in Resolution 206 are being addressed. Testimony noted that the MIPS system will not occur until 2019, indicating the need for protection in the interim period. Testimony also suggested amendment to the first two resolved clauses to remove the two-year limit for the look back period, and to expand the second resolved to address programs other than the Meaningful Use program. Your Reference Committee does not support the proposal to remove the two-year limit for the “look back” period but otherwise agrees with testimony and therefore recommends that Resolution 206 be adopted as amended.

(24) RESOLUTION 207 - NATIONAL PRACTITIONER DATA BANK

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 207 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate to the Health Resources and Services Administration that a physician’s surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank that investigating bodies be required to notify physicians when they are under investigation unless the physician has been notified that an investigation is underway. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 207 be amended by addition of a second Resolve to read as follows:

RESOLVED, That our AMA (1) recommend that medical staff bylaws require that physicians be notified in writing prior to the start of any investigation; and (2) include this recommendation in our AMA Physician’s Guide to Medical Staff Organization Bylaws. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 207 be adopted as amended.

HOD ACTION: Resolution 207 adopted as amended.

Resolution 207 asks that our American Medical Association advocate to the National Practitioner Data Bank that investigating bodies be required to notify physicians when they are under investigation. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 207, stating that physicians should not be reported to the National Practitioner Data Bank for surrendering their clinical privileges while under investigation unless they have been notified that an investigation is underway. Your Reference Committee also received amendments that, if added to Resolution 207, will provide additional, much needed protections to physicians by adding a new resolve clause under which our AMA would recommend that medical staff bylaws require that physicians be notified in writing prior to the start of any investigation; and that this be included in our AMA Physician's Guide to Medical Staff Organization Bylaws. Your Reference Committee also recommends amending Resolution 207 to reflect that advocacy should be directed to the Health Resources and Services Administration, which operates the National Practitioner Data Bank.

(25) RESOLUTION 208 - ATTORNEY ADS ON DRUG SIDE EFFECTS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association ~~seek by legislation and/or regulation~~ advocate for a requirement that attorney ~~commercial advertising~~ which may cause patients to discontinue medically necessary medications have appropriate and conspicuous warnings that patients should not discontinue medications without seeking the advice of their physician. (Directive to Take Action)

RECOMMENDATION B:

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 seek by legislation and/or regulation a requirement that attorney commercials which may cause patients to discontinue medically necessary medications have appropriate warnings that patients should not discontinue medications without seeking the advice of their physician. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of the intent of Resolution 208. Your Reference Committee agrees the advertisements addressed in Resolution 208 are alarming. They have the potential to endanger the safety of patients by causing them to stop taking prescribed medications without speaking to their physicians. We agree with testimony that our AMA needs to have flexibility to approach appropriate policymakers and regulators, as well as various agencies, on the issues raised in Resolution 208. Moreover, your Reference Committee concurs with testimony regarding the need to clarify what type of warnings are necessary in order to appropriately warn patients that they should not discontinue medications without seeking the advice of their physicians. Accordingly, your Reference Committee recommends that Resolution 208 be adopted as amended.

(26) RESOLUTION 213 - MERIT-BASED INCENTIVE PAYMENTS

RECOMMENDATION:

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

HOD ACTION: Resolution 213 amended by addition and deletion.

RESOLVED, That our American Medical Association ~~seek regulation or legislation~~ advocate to make the certified vendor-based EHRs accountable for

the provision of reports in a format suitable to satisfy physician reporting requirements in legal and/or financial fashion for the quality and reliability of the reports that they are more aligned with the physicians who are judged by them reports.

Resolution 213 asks that our American Medical Association seek regulation or legislation to make the certified vendor-based EHR's accountable in legal and/or financial fashion for the quality and reliability of the reports so that they are more aligned with the physicians who are judged by the reports. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 213. Testimony noted that our AMA is actively working to improve oversight of EHR vendors in many ways. For instance, our AMA has supported federal legislation that would require vendors to undergo a star rating performance system and incur financial penalties for data blocking. Second, our AMA has worked with the Office of the National Coordinator for Health Information Technology (ONC) to enhance accountability of vendors and recently wrote comments in support of a new proposed rule that would allow ONC to directly review the EHR certification process. Finally, the MIPS proposed rule also includes provisions that would require EHR vendors to undergo data integrity and submission criteria to ensure information is valid and accurate. To acknowledge this ongoing work and to support efforts that are broader than legal and financial requirements, an amendment to Resolution 213 was offered. Your Reference Committee recognizes the support for improving EHRs and the advocacy efforts already being pursued by our AMA. Therefore, your Reference Committee recommends that Resolution 213 be adopted as amended.

(27) RESOLUTION 214 - MEDICATIONS RETURN PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 214 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association update its current policy on medication disposal to support ~~daily~~ access to safe, convenient, and environmentally sound medication return for unwanted prescription medications (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 214 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support such a medication disposal program be fully funded by the pharmaceutical ~~manufacturers~~ industry, including costs for collection, transport and disposal of these materials as hazardous waste (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted as amended.

HOD ACTION: Resolution 214 adopted as amended.

Resolution 214 asks that our American Medical Association update its current policy on medication disposal to support daily access to safe, convenient, and environmentally sound medication return for unwanted prescription medications (New HOD Policy); that our AMA support such a medication disposal program be fully funded by the pharmaceutical manufacturers, including costs for collection, transport and disposal of these materials as hazardous waste (New HOD Policy); and that our AMA support changes in federal law or regulation that would allow a program for medication recycling and disposal to occur (New HOD Policy).

Your Reference Committee heard supportive testimony on Resolution 214. Your Reference Committee believes that it is the responsibility of the pharmaceutical industry and others in the manufacturing, supply, and distribution chain to help ensure that patients have ready access to dispose of unused and unwanted prescription drugs. Your Reference Committee also believes that this is needed as part of package of proposals to combat prescription drug misuse, diversion, overdose and death while also addressing the public health threat posed by the increased contamination of waterways and drinking water from, in part, improperly disposed prescription drugs. Therefore, your Reference Committee recommends that Resolution 214 be adopted.

(28) RESOLUTION 218 - MEASUREMENT OF DRUG COSTS TO ASSESS RESOURCE USE UNDER MACRA

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 218 be amended by addition to read as follows:

RESOLVED, That our American Medical Association work with Congress and the Centers for Medicare & Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 218 be adopted as amended.

HOD ACTION: Resolution 218 adopted as amended.

Resolution 218 asks that our American Medical Association work with Congress and the Centers for Medicare & Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk. (Directive to Take Action)

The majority of testimony presented to your Reference Committee supported Resolution 218. Testimony reflected concern that resource use measurement that includes Medicare Part B or Part D drug costs used to treat patients could inappropriately penalize physicians who select the most medically appropriate but expensive treatment for their patients. Testimony expressed concern that inclusion of drug costs could discriminate against patients with serious illness, and that physicians have no control of drug costs. Your Reference Committee also, however, heard testimony indicating that some physicians may in some cases want to have the flexibility to enter into arrangements where they do assume responsibility for the cost of drugs. Your Reference Committee recommends adopting Resolution 218, with an amendment which would allow physicians who so choose to assume financial risks for Medicare Part B or Part D medications in specific cases involve Physician Focused Alternative Payment Models.

(29) RESOLUTION 221 - ASSURANCE AND ACCOUNTABILITY FOR EPA'S STATE LEVEL AGENCIES

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 lobby the federal government to implement and enforce a requirement that~~ support requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations. (Directive to Take Action)

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 lobby the federal government to implement and enforce a requirement that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations. (Directive to Take Action)

Your Reference Committee heard testimony overwhelming supporting Resolution 221. Testimony indicated that in Flint, Michigan, one of the contributing factors to the drinking water crisis was that the responsible state agency did not ensure that the correct lead testing protocols were followed. In addition, the Environmental Protection Agency (EPA) did not conduct a regular accreditation or quality assurance review of the Michigan Department of Environmental Quality resulting in children being unnecessarily exposed to high levels of lead. Additional testimony was presented that lead contamination and other toxic substances is a serious public health concern that demands immediate attention. Your Reference Committee acknowledges this testimony. Your Reference Committee also believes that amending the language of Resolution to call on our AMA to support a requirement that the EPA conduct regular quality assurance reviews will add flexibility and scope to our AMA's ability to pursue the goals of Resolution 221 in all possible venues.

(30) RESOLUTION 224 - OCULAR INJURIES FROM AIR GUNS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve, second Resolve, and third Resolve of Resolution 224 be amended by addition and deletion on page 1, lines 27-34 and page 2, lines 1-5 to read as follows:

RESOLVED, That our American Medical Association encourage the use and provision of protective eyewear when using air guns. (New HOD Policy)

RESOLVED, That our AMA encourages education on the proper use of protective eyewear to avoid ocular injuries. (New HOD Policy).

~~RESOLVED, That our American Medical Association support legislation that requires air guns sold or transferred by a dealer or in a private sale to be packaged with appropriate and safe protective eyewear and a tamper resistant mechanical lock or other safety device (New HOD Policy); and be it further~~

~~RESOLVED, That our AMA support legislation that prohibits a minor from using an air gun on any public or private property unless the minor and persons known to be in the range of the air gun are wearing appropriate and safe protective eyewear (New HOD Policy); and be it further~~

~~RESOLVED, That our AMA support legislation that requires that any civil liability of a minor due to the minor's use of an air gun resulting in the injury or~~

~~death of another person shall be imposed upon the parent or guardian having custody or control of the minor for all purposes of civil damages and that a warning of this potential liability be attached to the air gun's tamper-resistant mechanical lock or other safety device. (New HOD Policy)~~

RECOMMENDATION B:

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

HOD ACTION: Resolution 224 adopted as amended.

Resolution 224 asks that our American Medical Association support legislation that requires air guns sold or transferred by a dealer or in a private sale to be packaged with appropriate and safe protective eyewear and a tamper-resistant mechanical lock or other safety device (New HOD Policy); that our AMA support legislation that prohibits a minor from using an air gun on any public or private property unless the minor and persons known to be in range of the air gun are wearing appropriate and safe protective eyewear (New HOD Policy); and that our AMA support legislation that requires that any civil liability of a minor due to the minor's use of an air gun resulting in the injury or death of another person shall be imposed upon the parent or guardian having custody and control of the minor for all purposes of civil damages and that a warning of this potential liability be attached to the air's gun's tamper-resistant mechanical lock or other safety device (New HOD Policy).

Your Reference Committee heard mixed testimony on in Resolution 224. Your Reference Committee agrees that air guns can cause serious ocular injuries with lasting impact on visual outcome in children and teenagers. However, considerable testimony expressed concern with the liability implications of Resolution 224 on parents, and expressed opposition to our AMA advocating for regulation on the use of legal items on personal property. Rather, testimony supported education about the risks inherent with the use of air guns. Your Reference Committee agrees with recommendations for education, and therefore, recommends that Resolution 224 be adopted as amended.

(31) RESOLUTION 225 - FRAUDULENT USE OF PRESCRIPTIONS

RECOMMENDATION A:

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

~~RESOLVED, That our AMA study current pathways that physicians have available to report possible fraudulent use of their prescriptions and disseminate this information throughout organized medicine. promote the recommendation to provide a clear pathway for individual physicians to communicate about any possible fraudulent use of their prescriptions. (New HOD Policy)~~

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 promote the efforts for state run electronic Prescription Monitoring Programs to allow individual physicians to access records of their prescribing of opioids, for their entire panel of patients, including patient names and prescription information (New HOD Policy); and that our AMA promote the recommendation to provide a clear pathway for individual physicians to communicate about any possible fraudulent use of their prescriptions (New HOD Policy).

Your Reference Committee heard testimony generally in support of the first resolve of Resolution 225, including that effective prescription drug monitoring programs can be helpful clinical support tools. Testimony also was clear that when a physician learns that his or her prescription identification has been used fraudulently, the physician needs to know to whom the physician should communicate that information. Your Reference Committee agrees with the testimony that physicians should have a definitive point of contact to help ensure that the fraudulent use of the prescription information can be immediately stopped, but also recognizes that the point of contact may be different in different states (e.g., law enforcement, medical board, pharmacy board). Therefore, your Reference Committee recommends that the first resolve of Resolution 225 be adopted and the second resolve be amended.

(32) RESOLUTION 227 - PHYSICIAN-PATIENT SMS TEXT MESSAGING AND NON-HIPAA COMPLIANT ELECTRONIC MESSAGING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 227 be amended by addition and deletion to read as follows:

That our American Medical Association study the medicolegal implications of ~~SMS~~ text messaging and other non-HIPAA-compliant electronic messaging between physicians, ~~and patients,~~ and members of the health care team, with report back at the ~~2016 Interim~~ 2017 Annual Meeting (Directive to Take Action); and be it further

That our AMA develop patient-oriented educational materials about ~~SMS~~ text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, ~~and patients,~~ and members of the health care team. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 227 be adopted as amended.

HOD ACTION: Resolution 227 adopted as amended with a change in title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 227 be changed to read as follows:

PHYSICIAN-PATIENT TEXT MESSAGING AND NON-HIPAA COMPLIANT ELECTRONIC MESSAGING

Resolution 227 asks that our American Medical Association study the medicolegal implications of SMS text messaging and other non-HIPAA-compliant electronic messaging between physicians and patients, with report back at the 2016 Interim Meeting (Directive to Take Action); and that our AMA develop patient-oriented educational materials about SMS text messaging and other non-HIPAA-compliant electronic messaging communication between physicians and patients (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 227, which emphasized the growing importance of text messaging in clinical practice. Testimony emphasized that many patients value the ability to communicate with their physicians via text, and many physicians likewise use texting as an effective medium through which they communicate with patients. Your Reference Committee received an amendment that would expand the study called for by Resolution 227 to include texts between physicians, patients, and health care providers. Your Reference Committee also received another amendment calling on our AMA to develop physician oriented (in addition to patient-oriented) educational materials concerning electronic messaging communication between physicians, and patients, and healthcare staff. Your Reference Committee agrees with these amendments,

and therefore recommends that Resolution 227 be adopted as amended. Because of the complexity of the issues involved, your Reference Committee also recommends that the report back be modified to the 2017 Annual Meeting.

(33) RESOLUTION 228 - NO LEGISLATIVE PILL COUNTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 228 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose legislative or other policies that arbitrarily restrict a patient's ability to receive effective, patient-specific, evidence-based, comprehensive pain care legislation that restricts a prescription for any controlled substance, including opioids, based on a specific number of pills or for a specific period of time less than 30 days. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 228 be adopted as amended.

HOD ACTION: Resolution 228 adopted as amended with a change in title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 22 be changed to read as follows:

LEGISLATIVE PAIN CARE RESTRICTIONS

Resolution 228 asks that our American Medical Association oppose legislation that restricts a prescription for any controlled substance, including opioids, based on a specific number of pills or for a specific period of time less than 30 days. (New HOD Policy)

Your Reference Committee heard overwhelming concern about legislative efforts to determine what is and is not the appropriate way to manage patients' pain care. The frustration over recent state legislative and federal efforts to specifically limit the dose or duration of a prescription was made abundantly clear to your Reference Committee, who notes that our AMA Task Force to Reduce Opioid Abuse has made the appropriate and comprehensive treatment of pain one of its key recommendations, along with ensuring that patients in pain are not stigmatized due to their medical condition(s).

At the same time, your Reference Committee is aware of multiple recent state legislative enactments to specifically limit the dose and/or duration of opioid prescriptions legislation that was enacted with the support of the state medical society. In addition, your Reference Committee is sensitive to the fact that the CDC recently issued guidelines that includes recommendations for limiting dose and/or duration in certain circumstances. Your Reference Committee does not believe that a science-based institution like the CDC would undertake such guidelines arbitrarily.

In both the state laws and the CDC guidelines, your Reference Committee further notes that there are several exceptions, including for cancer, hospice and palliative care, to name a few. Thus, while your Reference Committee agrees with and supports the testimony arguing against government intrusion into the practice of medicine, we also note that our state medical society colleagues and the CDC would almost certainly not support policies that would have an adverse effect on patients.

Moreover, testimony also highlighted that effective pain care often is not possible due to the policies of insurers to limit certain modalities and certain decisions by physicians. Therefore, to reflect how concern for patient care was the underlying and predominant feature of the testimony, your Reference Committee recommends that Resolution 228 be adopted as amended to emphasize the important interplay of physicians' clinical decision making with clear support for optimal patient care. Your reference Committee also recommends a change to the title of Resolution 228 to reflect the change in the language of the resolve.

(34) RESOLUTION 234 - TELEMEDICINE ENCOUNTERS BY THIRD PARTY VENDORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent~~provide the patient's established physician(s) with a full record of the provided telemedicine service, including the encounter record, prescriptions provided, studies ordered, and referrals within 24 consecutive hours of an encounter, as well as forward all lab or other diagnostic test results when they become available~~(Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, The model legislation and/or regulations also require the vendor to abide by laws addressing the privacy and security of patients' medical information~~offer the patient a real time, secure, and HIPAA compliant connection to their established physician through the vendor's program~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 234 be amended by the addition of a new Resolve to read as follows:

RESOLVED, That our AMA include in that model state legislation the following concepts based on AMA policy: 1) A valid patient-physician relationship must be established before the provision of telemedicine services; 2) 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; and 3) The standards and scope of telemedicine services should be consistent with related in-person services.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 234 be adopted as amended.

HOD ACTION: Resolution 234 adopted as amended.

Resolution 234 asks that our American Medical Association develop model legislation and/or regulations requiring telemedicine services or vendors to provide the patient's established physician(s) with a full record of the provided telemedicine service, including the encounter record, prescriptions provided, studies ordered, and referrals within 24 consecutive hours of an encounter, as well as forward all lab or other diagnostic test results when they become available (Directive to Take Action); that the model legislation and/or regulations also require the vendor to offer the patient a real-time, secure, and HIPAA compliant connection to their established physician through the vendor's program (Directive to Take Action); and that our AMA educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 234. Your Reference Committee heard testimony favorable to the third resolved, and heard that our AMA is already educating physicians about the adoption of telemedicine and related technologies in practice through efforts including the Steps Forward module on Telemedicine. At the same time, your Reference Committee heard concerns about the model legislation requested in the first Resolved; primarily, that the requested action would potentially conflict with patient rights regarding the privacy of medical records. However, your Reference Committee believes that Resolution 234 can be amended to address these concerns consistent with existing AMA telemedicine policy.

Your Reference Committee also agrees with those who testified that the proposed model legislation described in the second resolved is potentially problematic, as it is the responsibility of the covered entity or business associate to ensure the correct privacy safeguards are in place. For these reasons, your Reference Committee recommends that Resolution 234 be adopted as amended.

(35) RESOLUTION 240 - PATIENT SAFETY INCIDENTS RELATED TO USE OF ELECTRONIC HEALTH RECORDS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 240 be adopted by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the Office of the National Coordinator for Health IT (ONC) efforts to implement a Health IT Safety Center ~~urge Congress to create a National Health IT Safety Center that can implement an effective EHR safety program designed to reduce~~ minimize EHR-related patient safety risks through collection, aggregation and analysis of data reported from EHR-related adverse patient safety events and near misses (New HOD Policy).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 240 be adopted as amended.

HOD ACTION: Resolution 240 adopted as amended.

Resolution 240 asks that our American Medical Association urge Congress to create a National Health IT Safety Center that can implement an effective EHR safety program designed to reduce EHR-related patient safety risks through collection, aggregation and analysis of data reported from EHR-related adverse patient safety events and near misses. (New HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 240. However, testimony noted that the Office of the National Coordinator for Health Information Technology (ONC) was already working to establish a Health IT Safety Center with similar functions. To avoid duplicating efforts, an amendment was offered to support

the ongoing activities of this safety work. Your Reference Committee agrees with the goal of this Resolution and the importance of ensuring the safety of new technology. We agree that our efforts should build off of existing progress in this area. Therefore, your Reference Committee recommends that Resolution 240 be adopted as amended.

- (36) RESOLUTION 242 - PRESERVING A PERIOD OF STABILITY IN IMPLEMENTATION OF THE MEDICARE ACCESS AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT (MACRA) (P.L. 114-10)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 242 be amended by addition and deletion to read as follows

RESOLVED, That our AMA advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period ~~of no more than 90 days starting no earlier than January 1, 2018.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 242 be adopted as amended.

HOD ACTION: Resolution 242 adopted as amended.

Resolution 242 asks that our AMA advocate that CMS implement MIPS and APMs as is consistent with congressional intent when MACRA was enacted (Directive to Take Action); advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs. (Directive to Take Action); and advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a reporting period of no more than 90 days starting no earlier than January 1, 2018 (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 242. Those testifying emphasized that the proposed 2017 MIPS start date is too early and could negatively impact physicians. Additional testimony noted that a 90-day reporting period is a more feasible approach to reporting on Medicare requirements and decreases administrative burden. Others testifying noted that our AMA is actively working on comments to the proposed MACRA rule and that adopting specific policy at this time may limit our flexibility. This testimony further noted that the start date and performance period are key components of MACRA. Concern was raised, however, that locking-in a specific reporting period in the third resolve may be too prescriptive at this time given our AMA's ongoing advocacy efforts (working together with other national specialty and state Federation members) to urge CMS to provide a suitable time period for physicians to report under the MIPS program. There is also concern that the January 1, 2018 start date raises some operational issues. For example, CMS has stated that if MACRA performance measurement is postponed until 2018 then physicians will need to revert to reporting Meaningful Use Stage 3 on schedule in 2017. This would not be an efficient use of physician resources and could raise physician administrative burdens to comply with a short-lived program (or take the -5% penalty for noncompliance).

Your Reference Committee was provided with a detailed report from AMA staff regarding our AMA's extensive MACRA implementation advocacy work in collaboration with Federation members. Our AMA, together with other Federation groups, has raised serious concerns with CMS about the performance period starting January 1, 2017. Just last week in a meeting with our AMA and several specialty societies, senior CMS officials agreed to have further discussions regarding when the performance period should begin and how long it should last. Furthermore, our AMA and some specialty societies will be holding additional meetings with CMS' operations staff to explore what level of flexibility is feasible. Your Reference Committee heard that our AMA will continue to reach out to other medical societies to develop a common recommendation across medicine for a more rational start date that is better for physicians and technologically feasible for CMS. For these reasons, your Reference Committee believes that it would not be prudent at this time to include a specific start date or specify how long the performance period

should last. Therefore, your Reference Committee recommends that the third resolve be amended by addition and deletion.

(37) RESOLUTION 216 - HOSPITAL CONSOLIDATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 216 be referred.

HOD ACTION: Resolution 216 referred.

Resolution 216 asks that our American Medical Association study the current market power of hospitals and hospital conglomerates in the largest state metropolitan statistical areas (Directive to Take Action); and be it further that our AMA compare the market power of hospitals and hospital conglomerates and health plans (Directive to Take Action); that our AMA study the effects of hospital consolidation on price, availability of services, physician satisfaction, and quality (Directive to Take Action); and that our AMA develop an action plan to manage adverse effects of the current consolidation of hospitals and hospital conglomerates (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 216. Your Reference Committee agrees with concern expressed related to the potential effects that increased hospital consolidation may have on the health care prices, quality, the practice of medicine and physician satisfaction. We also agree with testimony expressing concern that determining the actual effects of hospital consolidation can be complex and resource intensive, depending on a number of factors including local market conditions, local physician-hospital relations, physician specialty and practice setting. Due to the complexity of the issues raised by this resolution and in order to give our AMA ample time to study these issues, your Reference Committee recommends referral.

(38) RESOLUTION 229 - EXPANSION OF U.S. VETERANS' HEALTH CARE CHOICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 229 be referred.

HOD ACTION: Resolution 229 referred.

Resolution 229 asks that our American Medical Association adopt policy that the Veterans Health Administration expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the VA system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage (New HOD Policy); and that our AMA actively support federal legislation to achieve this reform of veterans' health care choices (New HOD Policy).

The majority of testimony that your Reference Committee received requested that Resolution 229 be referred to the Board of Trustees for study. Your Reference Committee also heard testimony that AMA policy already supports encouraging the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for veterans, and that our AMA has actively supported improvements to the delivery and access of care to our nation's veterans through its support of the Veterans Access, Choice, and Accountability Act of 2014 and its current support of pending legislation in Congress that would further reform the Veterans Choice Program and the delivery of veterans' health care. Testimony indicated that, allowing all veterans to access health care outside the VA through premium support is a complicated and controversial issue, with implications not only for the VA, but also for Medicare, the private health insurance market, and the entire health care system. Additionally, testimony expressed great concern that efforts to increase veteran's access to care, whether through premium support or through other mechanisms, not impose additional costs on veterans.

Your Reference Committee believes that our nation's veterans deserve timely access to the highest quality care, and that the Veteran's Choice Program needs to be reformed so that the program is easier to navigate and access. Your Reference Committee also believes that the issues raised in this resolution could benefit from further study before being adopted as AMA policy, and therefore recommends that Resolution 229 be referred.

(39) RESOLUTION 232 - CLOSING GAPS IN PRESCRIPTION DRUG MONITORING PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 232 be referred.

HOD ACTION: Resolution 232 referred.

Resolution 232 asks that our American Medical Association advocate for the inclusion of all controlled substance prescriptions, regardless of their private, public, military or governmental source, in the reporting requirements for Prescription Drug Monitoring Programs (PDMP) (New HOD Policy); and that our AMA advocate for the inclusion of all controlled substances administered or dispensed by opioid treatment programs in the reporting requirements for Prescription Drug Monitoring Programs (PDMP) (Modify Current HOD Policy).

Your Reference Committee heard considerable testimony in support of using prescription drug monitoring programs (PDMPs) to help inform physicians' decision making when considering whether to prescribe controlled substances. Many commented that when PDMPs contain relevant, timely information that is available at the point of care, PDMPs can provide helpful information at the point of care. Testimony also was clear, however, that many state PDMPs are less than functional for a variety of reasons, including that information from Opioid Treatment Providers (OTPs), the Veteran's Health Administration and other sources are not included in PDMPs. While your reference committee agrees with the general tenor that PDMPs can be most helpful when they contain all relevant information, testimony also raised important issues regarding patient privacy, including that OTPs must comply with the strict privacy requirements under 42 CFR Part 2 governing disclosure of patient records, and that state PDMPs may not all meet those requirements. Furthermore, your reference committee appreciates testimony that questioned the broad range of federal and state privacy requirements that may be affected by the issues raised by this resolution. For these reasons, your Reference Committee recommends referral so that these issues can be researched in more detail.

Your Reference Committee heard significant testimony in favor of referral to better address this complex matter, which includes privacy issues. Your Reference Committee also heard testimony on the importance of striking the right balance on this important topic. Your Reference Committee agrees with this testimony and recognizes the urgency of this issue. Therefore, your Reference committee recommends that Resolution 232 be referred, and requests report back at the 2016 Interim Meeting.

(40) RESOLUTION 201 - REPEAL OF ANTI-KICKBACK SAFE HARBOR FOR GROUP PURCHASING ORGANIZATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 201 be referred for decision.

HOD ACTION: Resolution 201 referred for decision.

Resolution 201 asks that our American Medical Association support the repeal of the "Anti-Kickback Safe Harbor" for Group Purchasing Organizations. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 201. Your Reference Committee heard impassioned testimony on the important problem of drug shortages, but also received substantial testimony that eliminating the Anti-Kickback safe harbor for Group Purchasing Organizations would not directly address this issue and could create other potential complications in the pharmaceutical market. Your Reference Committee believes

that the issues raised warrant further study and expedient resolution, and therefore, recommends that Resolution 201 be referred for decision.

(41) RESOLUTION 226 - OPPOSITION TO TRANS PACIFIC PARTNERSHIP

RECOMMENDATION:

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

HOD ACTION: Resolution 226 referred for decision.

Resolution 226 asks that our American Medical Association oppose US ratification of the Transpacific Partnership (TPP) as currently worded (New HOD Policy); and that our AMA notify Congressional leaders, the President, and national media outlets of this policy (Directive to Take Action).

Your Reference Committee heard conflicting testimony on Resolution 226. Those in favor of Resolution 226 voiced concern that the Trans-Pacific Partnership (TPP) would compromise the ability of the U.S. to safeguard food and drugs, because U.S. food and drug regulations would be subject to an international tribunal. Testimony reflected however, that the TPP is extraordinarily complex, and that language that would need to be reviewed would not be available until after the election. Given this mixed testimony, your Reference Committee recommends that Resolution 226 be referred to the Board of Trustees for decision.

(42) RESOLUTION 231 - CMS AUDITS AND CLAWBACKS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 231 be referred for decision.

HOD ACTION: Resolution 231 adopted.

Resolution 231 asks that our American Medical Association undertake advocacy efforts to: 1) Persuade CMS to redefine “primary care provider” for purposes of the regulations governing the enhanced payments to primary care physicians mandated by section 1202 of the Health Care and Education Reconciliation Act of 2010 (“Section 1202”). Such definition should include the current providers board certified in a specialty considered primary care; or providers attesting to the 60% threshold under the same methodology as used in the parallel statutory formula in Section 5501(a) of PPACA; or, in states utilizing managed care organizations, providers who are, or have been held out by such MCOs as primary care providers by having patients assigned to such primary care providers and holding such providers out to the public as primary care providers; and the 60% Threshold formula previously utilized in attestation; 2) Persuade CMS to order that the audits conducted, or to be conducted, of the enhanced payments to primary care physicians, by state Medicaid agencies or their agents be conducted pursuant to the amended flexible formula redefining “primary care provider;” and 3) Persuade CMS to order that state Medicaid agencies, or their agents, immediately cease recoupments, or hold amounts of funds already recouped in trust, until a new audit using the redefined formula can be completed. (Directive to Take Action)

Your Reference Committee heard limited testimony in favor of Resolution 231. Testimony was presented that the methodology adopted by CMS to define primary care provider for purposes of the Medicaid audits on primary care physicians under the temporary increase under Medicaid to Medicare rates for certain primary care physicians was flawed and did not reflect what a primary care physician is. Testimony further noted that as a result, many Tennessee physicians, failed the state audit and were recouped thousands, in some cases hundreds of thousands, of dollars, to be returned to the federal government. Your Reference Committee notes, however, that at this time, no state other than Tennessee has reported similar issues related to audits or recoupments. Testimony also indicated that despite the advocacy of state legislators and the entire Tennessee congressional delegation have not convinced CMS to alter its position. Your Reference Committee sympathizes with the Tennessee physicians affected by the Tennessee audits. Given the complicated issues and concerns raised by Resolution 231, your Reference Committee recommends that Resolution 231 be referred to the Board of Trustees for decision.

(43) RESOLUTION 209 - MEDICARE PART B DOUBLE DIPPING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 209 not be adopted.

HOD ACTION: Resolution 209 referred.

Resolution 209 asks that our American Medical Association seek legislation to stop the practice by the federal government of deducting Medicare Part B coverage costs from the Social Security checks of retirees, as well as from salaries individuals may earn after they draw on social security benefits. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 209. Your Reference Committee heard testimony supportive of the drafters' intentions, but testimony also indicated that the premises of Resolution 209 are factually inaccurate and that the practices it seeks to curtail do not in fact occur. Accordingly, your Reference Committee recommends that Resolution 209 not be adopted.

(44) RESOLUTION 212 - INTERSTATE MEDICAL LICENSURE COMPACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 212 not be adopted.

HOD ACTION: Resolution 212 not adopted.

Resolution 212 asks that our American Medical Association oppose the Federation of State Medical Boards' Interstate Medical Licensure Compact (Compact). (New HOD Policy)

Your Reference Committee heard substantial testimony in opposition to Resolution 212. In particular, testimony highlighted the fact that the Compact is an alternative approach to medical licensure in states other than a physician's primary state of licensure, and that traditional pathways to licensure remain for any physician who does not qualify for the Compact's expedited process, or who chooses to not participate in the Compact. Testimony also offered that specialty certification is an initial requirement for participation in the Compact because those states that had existing expedited pathways uniformly required specialty certification, and as such, the same would have to be included in the Compact for those states to participate. Testimony from a member of the Interstate Medical Licensure Compact Commission also clarified that the Compact's definition of physician is for purposes of the Compact only, and does not alter a state's medical practice act.

Your Reference Committee heard testimony suggesting that the Compact is essential to initiatives to create a federal medical license or federal telemedicine license. Finally, your Reference Committee heard testimony from many of the seventeen states that have already joined the Compact, urging defeat of this resolution. Your Reference Committee understands that concerns remain regarding the Compact and Maintenance of Certification (MOC), but heard testimony clarifying that the Compact itself does not require MOC. However, your Reference Committee is aware that the Council on Legislation has approved, and your Board of Trustees will be considering at this meeting, model state legislation that would address these issues. Your Reference Committee believes that the Compact is a mechanism through which the medical licensure process can be modernized while preserving state authority to regulate the practice of medicine, and therefore, recommends that Resolution 212 not be adopted.

(45) RESOLUTION 230 - VETERANS HEALTH ADMINISTRATION
TRANSPARENCY AND ACCOUNTABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 230 not be adopted.

HOD ACTION: Resolution 230 not adopted.

Resolution 230 asks that our American Medical Association adopt as policy that the Veterans Health Administration be required to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost effectiveness (New HOD Policy); and that our AMA actively support federal legislation to achieve this reform of Veterans Health Administration transparency and accountability (New HOD Policy).

Your Reference Committee heard mixed testimony on Resolution 230. Testimony in favor of adoption stated that the VA should be more transparent and accountable with regard to its operations. Testimony against adoption of Resolution 230 was presented that the VHA is already required by law to report publicly on its operations, especially related to access to care, quality, safety, patient experience, and timeliness through the Veterans Choice Act and funding bills, and pending legislation in Congress would impose additional audit and reporting requirements on the VA to make it more accountable and transparent with regard to its operations. Your Reference Committee believes that the VA should be more transparent and accountable with regard to its operations but notes that it is already required by law to report publicly on its operations, especially related to access to care, quality, safety, patient experience, and timeliness through the Veterans Choice Act and funding bills, and further notes that pending legislation in Congress would impose additional audit and reporting requirements on the VA. Accordingly, your Reference Committee believes that recommendations in this resolution are not needed since the reporting called for is already required and/or is being done, and therefore recommends that Resolution 230 not be adopted.

(46) RESOLUTION 237 - COLLECTIVE BARGAINING FOR PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 237 not be adopted.

HOD ACTION: Resolution 237 not adopted.

Resolution 237 asks that our American Medical Association support the right of all physicians to form local and/or regional negotiating units consistent with our medical ethics and professionalism for the purpose of collectively bargaining with employers, insurers, government, or managed care entities on issues of health care quality, patient rights, and physician rights (New HOD Policy); and that our AMA amend our AMA Code of Medical Ethics so that our policy will oppose any affiliation of physician negotiating units with labor unions or other entities unless such affiliation includes a right to strike (Modify Current HOD Policy).

Your Reference Committee heard mixed testimony on Resolution 237. Testimony supporting Resolution 237 emphasized the need for physicians to form national, as well as local, bargaining units, and that physicians should be able to exercise the right to strike as part of collective bargaining. The majority of testimony presented at the Reference Committee, however, opposed Resolution 237 on the grounds that our AMA should not be advocating for physicians' right to strike. Your Reference Committee also notes that current AMA policies H-385.946 and H-385.976 already support physicians' right to engage in collective negotiations. Because the weight of testimony opposed Resolution 237 and existing AMA policy already supports collective bargaining, your Reference Committee recommends that Resolution 237 not be adopted.

(47) BOARD OF TRUSTEES REPORT 23 - REMOVING FINANCIAL BARRIERS TO PARTICIPATION IN CLINICAL TRIALS FOR MEDICARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 23 be filed.

HOD ACTION: Board of Trustees Report 23 filed.

Your Reference Committee heard minimal testimony related to the Board of Trustees decision related to the underlying resolution of Board of Trustees Report 23. Your Reference Committee, therefore, recommends that Board of Trustees Report 23 be filed.

REPORT OF REFERENCE COMMITTEE C

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 2 - UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION

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: Council on Medical Education Report 2 adopted.

Council on Medical Education Report 2 asks that our AMA 1) a) examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification, and b) determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways; 2) reaffirm Policy D-275.954 (9), Maintenance of Certification and Osteopathic Continuous Certification, which asks the American Board of Medical Specialties (ABMS) to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting maintenance of certification (MOC) and certifying examinations; 3) reaffirm Policy D-275.954 (4), which encourages 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; and 4) ask the ABMS to encourage its member boards to review their MOC policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on MOC activities relevant to their practice.

Your Reference Committee heard overwhelming support for this comprehensive report, which provides an update on the Council on Medical Education's efforts with the American Board of Medical Specialties during the last year to improve the Maintenance of Certification (MOC) program. During testimony, it was noted that efforts to improve the MOC process are a work in progress. Therefore, your Reference Committee recommends adoption of Council on Medical Education Report 2.

- (2) RESOLUTION 303 - RESEARCH AND MONITORING TO ENSURE ETHICS OF GLOBAL HEALTH PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 303 be adopted.

HOD ACTION: Resolution 303 adopted.

Resolution 303 asks that our American Medical Association amend Policy H-250.993 by addition to read as follows:

H-250.993 Overseas Medical Education Developed by US Medical Associations

The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measureable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to

global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives.

Your Reference Committee heard limited but favorable testimony in support of this item. The number of students participating in summer global health projects after completing their first year of medical school is increasing, but AMA policy does not explicitly address these projects. Your Reference Committee feels the proposed change to AMA policy is appropriate and recommends adoption of Resolution 303.

(3) RESOLUTION 310 - STANDARDIZING THE ALLOPATHIC RESIDENCY MATCH SYSTEM AND TIMELINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 310 be adopted.

HOD ACTION: Resolution 310 referred.

Resolution 310 asks 1) That our American Medical Association support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties; and 2) That our AMA work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, the Society of University Urologists, the American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program.

Your Reference Committee heard testimony both in support of and opposition to Resolution 310, but the preponderance of testimony favored adoption. Testimony focused on the difficulties of couples attempting to navigate both a specialty match and the National Resident Matching Program (NRMP) match; the observation that the NRMP is much more transparent about its data, which allows individuals in the NRMP match to better gauge their competitiveness than individuals participating in a specialty match; and a concern that specialties that run their own matches have a potential financial conflict of interest. Testimony offered in opposition to the resolution came mostly from the affected specialties, which expressed satisfaction with the current system and a reluctance to transition to a shared match and timeline. Although there were concerns, your Reference Committee feels that the majority of students would benefit from an aligned match process and timeline, and therefore recommends that Resolution 310 be adopted.

(4) RESOLUTION 318 – EXPANSION OF PUBLIC SERVICE LOAN FORGIVENESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 318 be adopted.

HOD ACTION: Resolution 318 adopted.

Resolution 318 asks that our AMA study mechanisms to allow residents and fellows working in for-profit institutions to be eligible for Public Service Loan Forgiveness.

Your Reference Committee heard limited but supportive testimony in favor of this item. The Public Service Loan Forgiveness program allows debt relief for medical professionals who work for a non-profit entity for 10 years. The National Resident Matching Program matching algorithm does not allow medical students the opportunity to choose a program based on non-profit status. Additionally, residents and fellows who match with a non-profit university-based residency or fellowship program are excluded if they are officially employees of an affiliated for-profit hospital or health system. A study of expanding the Public Service Loan Forgiveness program to residents and fellows working in for-profit institutions is appropriate. Therefore, your Reference Committee recommends adoption.

(5) RESOLUTION 319 – SPECIALTY-SPECIFIC ALLOCATION OF GME FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 319 be adopted.

HOD ACTION: Resolution 319 adopted.

Resolution 319 asks that our AMA support specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

Your Reference Committee heard strong testimony in support of this resolution. Existing AMA policy is supportive of enhancing funding for GME, but does not call for specific specialties to receive funding at the expense of others. Some testimony was heard in support of preferred funding for first-certificate programs in order to promote specific workforce goals, but the majority did not agree with any degree of partiality. Additionally, your Reference Committee felt that the resolution as written does not preclude additional discussion regarding the importance of a national workforce plan that addresses population health needs. Therefore, your Reference Committee recommends that Resolution 319 be adopted.

(6) RESOLUTION 320 – EXPANDING GME CONCURRENTLY WITH UME

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 320 be adopted.

HOD ACTION: Resolution 320 adopted.

Resolution 320 asks that our AMA study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.

Your Reference Committee heard supportive and well-reasoned testimony overwhelmingly in favor of this resolution. Multiple individuals aptly noted that the number of new medical schools, and enrollment in existing institutions has expanded substantially of late, without a corresponding increase in the number of graduate medical education (GME) slots, and a concern was voiced that the number of U.S. medical graduates (both allopathic and osteopathic) likely will approach the number of U.S. GME positions within the next one to two decades. It was further acknowledged that the Accreditation Council for Graduate Medical Education (ACGME) is currently looking at this important issue. Additionally, a study on this topic could be linked to work underway by our AMA with respect to Resolution 902-I-15, related to a national campaign to educate Americans regarding GME. Some testimony requested the addition of a second resolve, to ask the AMA to advocate for expansion in resident and fellowship positions in proportion to expansions in medical school student populations and the needs of the populace. Other testimony discussed the need for a national workforce plan that appropriately addresses specialty and geographic shortages. Testimony in opposition to the addition of the proposed second resolve focused on concerns that advocating for U.S. medical schools to limit class sizes could be construed as restraint of trade. Both the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have the authority to set standards for schools, but they must approve any school that meets those standards; they cannot arbitrarily prohibit the establishment of new schools. While it may be a moral obligation for the medical schools themselves to consider the issue of the narrowing gap between the number of medical school graduates and the number of residency positions, it is not a legal obligation. For these reasons, your Reference Committee recommends that Resolution 320 be adopted.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2006 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be amended by addition, to read as follows:

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of H-295.912, Education of Medical Students and Residents about Domestic Violence Screening, which should be retained and the remainder of this report be filed. (Directive to Take Action)

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.

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard limited but generally supportive testimony on this item, which represents the work of the Council on Medical Education to streamline and make more efficient our existing AMA policy, while not seeking to develop any new policy. Additional testimony was heard that questioned the rationale of a revision to Policy H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, specifically proposed item 12, where language is inserted from Policy H.310.962, Residency Programs Prejudiced Against Applicants with Ethnic Names. This policy, H.310-962, is being retained as still relevant and incorporated into Policy H-255.988, which now states: “Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.” The phrase “status as an IMG or” was inserted into revised H-255.988, to incorporate the concept of the following phrase of H-255.988, which is being deleted: “In particular, these AMA representatives should emphasize that AMA policy does not prohibit the appointment of qualified graduates of foreign medical schools to residency training programs.” Your Reference Committee believes this is an appropriate revision. Other testimony was heard in relation to D-480.981, Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine, which is marked for sunseting in the report. The testimony requested addition of the following rationale to support sunseting of this item: “Also superseded by H-480.973, Unconventional Medical Care in the United States, which reads, in part, ‘(1) encourages the Office of Alternative Medicine of the National Institutes of Health to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices.’” Your Reference Committee supports the intent of this addition, but believes it is superfluous, as it does not change the final action on this policy (i.e., sunseting). Finally, testimony was heard in opposition to sunseting of H-295.912, Education of Medical Students and Residents about Domestic Violence Screening, in that the policy that was cited as superseding this policy, H-60.992, Missing and Exploited Children, is not germane and does not fully reflect the issue of domestic abuse. Your Reference Committee concurs and therefore proffers the revised language as shown, and recommends adoption as amended.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 3 - ADDRESSING THE INCREASING NUMBER OF UNMATCHED MEDICAL STUDENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 3 be amended by addition of a new fourth recommendation, to read as follows:

4. That our AMA encourage the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match (Directive to Take Action).

RECOMMENDATION B:

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

HOD ACTION: Council on Medical Education Report 3 adopted as amended.

Council on Medical Education Report 3 asks that our AMA 1) reaffirm D-305.967 (4) and (22), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education: “4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation” and “22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation”; 2) reaffirm Policy H-200.954 (4) (5) (6) (7), US Physician Shortage: “Our AMA: ...(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates’ practice locations; (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates’ eventual practice in underserved areas and with underserved populations; (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas”; and 3) reaffirm D-310.977 (11), National Resident Matching Program Reform: “Our AMA: . . . (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.”

Your Reference Committee heard overwhelming testimony in support of the report, although several comments expressed regret that data regarding osteopathic graduates and international medical graduates were not included in the report’s overall scope, and requested that the Council on Medical Education address these issues in a separate report. A request was made to change the title of the report to “Addressing the Increasing Number of Unmatched Eligible Individuals,” in order to address content related to non-U.S. trained physicians, but your Reference Committee believes that the title accurately reflects the report’s substance and intent. Support was also expressed for adding a recommendation that calls for our AMA to encourage stakeholders to identify best practices, including career counseling, to facilitate matches and reduce the number of individuals who do not match. In addition, interest was expressed in the Council on Medical Education’s planned report for A-17, which will further examine the plight of unmatched medical students and study ways to reengage in medicine those individuals who do not match. For these reasons, your Reference Committee recommends that Council on Medical Education Report 3 be adopted as amended.

- (9) COUNCIL ON MEDICAL EDUCATION REPORT 4 - RESIDENT AND FELLOW COMPENSATION AND HEALTH CARE SYSTEM VALUE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 4 be amended by addition to read as follows:

1. That American Medical Association (AMA) Policy H-305.988 be amended by addition and deletion, to read as follows:

(10) supports AMA monitoring of trends that may lead to a reduction in ~~stipends~~ compensation and benefits provided ~~paid~~ to resident physicians. (Amend HOD Policy)

RECOMMENDATION B:

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

3. That our AMA encourage teaching institutions to ~~provide~~ explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. (New HOD Policy)

RECOMMENDATION C:

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

HOD ACTION: Council on Medical Education Report 4 adopted as amended.

Council on Medical Education Report 4 asks that our AMA 1) reaffirm Policy H-305.988, which states that our AMA (10) supports AMA monitoring of trends that may lead to a reduction in stipends paid to resident physicians; (12) will advocate that resident and fellow trainees should not be financially responsible for their training; 2) modify Policy H-310.922 by addition and deletion to read as follows: “~~Our AMA encourages that residents’ level of training, cost of living, and other factors relevant to appropriate compensation be considered by graduate training programs when establishing salaries for residents. Our AMA encourages teaching institutions to base residents’ salaries on the resident’s level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living~~”; 3) encourage teaching institutions to provide benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation; 4) collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services; 5) monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows; and 6) continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time based to competency-based medical education on residents’ compensation and lifetime earnings.

Your Reference Committee heard significant testimony in support of this report, which explores complex issues around resident compensation and the significant value that residents provide to patients and the health care system. Using the phrase, “compensation and benefits” rather than the word “stipend” in Recommendation 1 addresses residents’ concerns about their total compensation packages. Replacing the word “provide” in Recommendation 3 with the word “explore” avoids mandating action on the part of residency programs. With these changes, your Reference Committee recommends adoption of CME Report 4 as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 5 - ACCOUNTABILITY AND TRANSPARENCY IN GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 6 of Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

6. That our AMA monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and that our AMA report back to the House of Delegates, ~~as needed~~, regularly on important changes in the landscape of GME funding. (Directive to Take Action).

RECOMMENDATION B:

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

HOD ACTION: Council on Medical Education Report 5 adopted as amended.

Council on Medical Education Report 5 asks that our AMA 1) endorse the following principles of social accountability and promote their application to GME funding: a. Adequate and diverse workforce development; b. Primary care and specialty practice workforce distribution; c. Geographic workforce distribution; and d. Service to the local community and the public at large; 2) encourage transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees; 3) believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: a. Resident salary and benefits; b. Administrative support for graduate medical education; c. Salary reimbursement for teaching staff; d. Direct educational costs for residents and fellows; and e. Institutional overhead; 4) reaffirm Policy D-305.967 (8) (22) (23), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education: "(8), Our AMA will vigorously advocate for the 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 GME." "(22), Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation." "(23) Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME"; 5) reaffirm Policy H-305.988 (12), Cost and Financing of Medical Education and Availability of First-Year Residency Positions: "Our AMA...(12) will advocate that resident and fellow trainees should not be financially responsible for their training"; 6) monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and that our AMA report back to the House of Delegates, as needed, on important changes in the landscape of GME funding.

Your Reference Committee heard universal support for this report. Testimony highlighted the importance of transparency and its role in appropriate geographic distribution of physicians, especially in specialties of need, and acknowledgment that the report correctly calls attention to a public good that is consistently underfunded when examined in the context of societal need. The authors of the report were also complimented for summarizing a complex topic in a relatable and relevant manner. A request was made that the report be updated annually; however, your Reference Committee recognizes that, in the absence of necessary data or any noteworthy changes in the GME funding climate, our AMA would be better served by updating the report regularly, as required. Therefore, your Reference Committee recommends that Council on Medical Education Report 5 be adopted as amended.

(11) COUNCIL ON MEDICAL EDUCATION REPORT 6 - TELEMEDICINE IN GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 of Council on Medical Education Report 6 be amended by addition and deletion, to read as follows:

1. That our AMA support ~~incorporating~~ the appropriate use of telemedicine into the education of medical students, residents, fellows and practicing physicians. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Council on Medical Education Report 6 adopted as amended with a change in title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Council on Medical Education Report 6 be changed to read as follows:

TELEMEDICINE IN MEDICAL EDUCATION

Council on Medical Education Report 6 asks that our AMA 1) support incorporating telemedicine into the education of medical students, residents, fellows and practicing physicians; 2) encourage appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations; 3) collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals; 4) encourage the Liaison Committee on Medical Education (LCME) and Accreditation Council for Graduate Medical Education (ACGME) to include core competencies in telemedicine in undergraduate medical education and graduate medical education training; and 5) reaffirm policies H-480.946, H-480.974, D-480.970, and H-480.968, which can reduce some of the barriers to telemedicine education, which have been identified.

Your Reference Committee heard overwhelming testimony in support of this report, which was felt to be timely and relevant, due to the increased, and increasingly valuable, implementation of this technological enhancement to medical practice. Testimony reflected the value of teaching and learning the appropriate use of telemedicine in training and practice, and noted the importance of issues related to teleprecepting. Some testimony noted that the scope of the report extends beyond graduate medical education, and recommended that the title be modified to reflect the entirety of its content. Testimony also reflected a concern that the first resolve, as written, could be construed as a curricular mandate, and support was voiced to amend this recommendation in a way that stresses the importance of methodology and care delivery. Online testimony expressed concern that the term “telemedicine,” as used in the report, would not encompass other, related terms such as telehealth or mHealth; however, your Reference Committee felt that the report adequately addressed the reasoning for the use of the term “telemedicine” and does not believe change is needed in this regard. Therefore, your Reference Committee recommends adoption of Council on Medical Education Report 6 as amended.

(12) RESOLUTION 301 - RECOGNIZING THE ACTUAL COSTS OF STUDENT LOANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 301 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~ask~~work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at ~~time of graduation~~completion of graduate medical education training. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

HOD ACTION: Resolution 301 adopted as amended.

Resolution 301 asks 1) That our American Medical Association consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates; 2) That our AMA amend Policy D-305.984 by addition to include Grad-PLUS loans, as follows:

D-305.984, Reduction in Student Loan Interest Rates

1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%. 2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program. 3) That our AMA advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden; and 4) That our AMA ask the Association of American Medical Colleges to collect data and report student indebtedness that includes total loan costs at time of graduation.

Your Reference Committee heard overwhelming support for this item. The fourth Resolve calls on our AMA to ask the Association of American Medical Colleges (AAMC) to collect data and report on student indebtedness, using methodology that includes total loan costs at the time of graduation. The AAMC already collects and reports on these data, but there was significant concern that the debt acquired in the process of becoming a physician is actually under-reported, because interest that accumulates during residency or fellowship is not reflected in these data. The recommended change incorporates these concerns. Accordingly, your Reference Committee recommends adoption of Resolution 301 as amended.

(13) RESOLUTION 309 - CONTINUING MEDICAL EDUCATION PATHWAY FOR RECERTIFICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~call for the immediate end of any mandatory, recertifying examination by~~ continue to work with the American Board of Medical Specialties (ABMS) to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure exam or other certifying organizations as part of the recertification process (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 309 be deleted.

~~RESOLVED, That the AMA voice this policy directly to the ABMS and other certifying organizations (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 309 be deleted.

~~RESOLVED, That there be a report back to the AMA HOD by the 2017 Annual Meeting. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 309 be adopted as amended.

HOD ACTION: Original language of the first Resolve adopted as amended, with addition of fourth and fifth Resolves, to read as follows:

RESOLVED, That our American Medical Association call for the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

RESOLVED, That our AMA continue to work with the American Board of Medical Specialties (ABMS) to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam.

RESOLVED, That our AMA continue to support the requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

Resolution 309 asks 1) That our American Medical Association call for the immediate end of any mandatory, recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process; 2) That our AMA support a recertification process based on high quality, appropriate CME material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning; 3) That our AMA reaffirm Policies H-275.924 and D-275.954; 4) That the AMA voice this policy directly to the ABMS and other certifying organizations; and 5) That there be a report back to the AMA HOD by the 2017 Annual Meeting.

Your Reference Committee heard testimony in support of Resolution 309. Our AMA, through the Council on Medical Education, works with the American Board of Medical Specialties (ABMS) to encourage the sharing of best practices between specialty boards about all aspects of Maintenance of Certification (MOC), including Part III, the secured, high-stakes examination, for some but not all of the boards. The ABMS member boards are independent entities, and it is not within the purview of the ABMS to mandate the cessation of the secure examination. However, the Council will continue to work collaboratively with the ABMS and, when appropriate, with specific boards regarding alternative models for the secure exam. In addition, the Council continues to maintain an active dialogue with the ABMS, and Council members and AMA staff meet regularly with ABMS leaders to communicate

questions and concerns about MOC. Policy D-275.954 (1) calls on our AMA to continue to monitor the evolution of MOC, 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 HOD regarding the MOC process. For these reason, your Reference Committee recommends that Resolution 309 be adopted as amended.

- (14) RESOLUTION 311 - TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS
 RESOLUTION 316 - TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS
 RESOLUTION 317 - TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO U.S. MEDICAL SCHOOLS
 RESOLUTION 321 - TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 311, 316, 317, and 321.

TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards, National Board of Medical Examiners, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education-accredited and Commission on Osteopathic College Accreditation-accredited medical school graduates who have passed a school-administered, clinical skills examination (Directive to Take Action); and be it further

RESOLVED, That our AMA work to: 1) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; 2) encourage a significant and expeditious increase in the number of available testing sites; 3) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and, 4) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency (New HOD Policy).

HOD ACTION: Alternate Resolution 311 adopted as amended in lieu of Resolutions 311, 316, 317, and 321 to read as follows:

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States

Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as with a requirement for to pass a Liaison Committee on Medical Education-accredited and/or Commission on Osteopathic College Accreditation-accredited medical school graduates who have passed a school-administered, clinical skills examination.

RESOLVED, That our AMA work to: 1) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; 2) encourage a significant and expeditious increase in the number of available testing sites; 3) allow international students and graduates to take the same examination at any available testing site; 34) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and, 45) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.

Resolution 311 asks 1) That our American Medical Association work with the Federation of State Medical Boards and state medical licensing boards to advocate for the elimination of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) exam and the COMLEX Level 2-PE (Performance Evaluation) as a requirement for Liaison Committee on Medical Education-accredited and Commission on Osteopathic College Accreditation-accredited medical school graduates who have passed a school-administered, clinical skills examination; and 2) That our American Medical Association amend AMA Policy D-295.998 by addition to read as follows:

D-295.988, Required Clinical Skills Assessment During Medical School

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited or American Osteopathic Association Commission on Osteopathic College Accreditation (COCA)-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.

Resolution 316 asks 1) That our American Medical Association, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school-administered, clinical skills examination; 2) That our AMA advocate for medical schools and medical licensure stakeholders to create standardizing a clinical skills examination that would be administered at each Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school in lieu of United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) and that would be a substitute prerequisite for future licensure exams; and 3) That AMA to amend Policy D-295.998 by addition and deletion as follows:

D-295.998, Required Clinical Skills Assessment During Medical School

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered, clinical skills examination to graduate from medical school.

Resolution 317 asks 1) That our American Medical Association work with the Federation of State Medical Boards and state medical licensing boards to advocate for the elimination of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) exam as a requirement for Liaison Committee on Medical Education-accredited graduates who have passed a school-administered, clinical skills examination; and 2) That our AMA amend Policy D-295.998 by addition and deletion to read as follows:

D-295.998, Required Clinical Skills Assessment During Medical School

Our AMA will advocate that encourage its representatives to the Liaison Committee on Medical Education (LCME) ~~to ask the LCME, to 1)~~ determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.

Resolution 321 asks 1) That our AMA, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school administered, clinical skills examination; and 2) That our AMA amend D-295.998 by insertion and deletion as follows:

D-295.998, Required Clinical Skills Assessment During Medical School

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school; and 3) That our AMA advocate for medical schools and medical licensure stakeholders to create guidelines standardizing the clinical skills examination that would be administered at each LCME-accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and would be a substitute prerequisite for future licensure exams.

Your Reference Committee heard extensive and impassioned testimony on both sides of this item, but the substantial preponderance of testimony was in favor of adoption of these resolutions. A number of key and compelling points were made, including the significant costs and burden to medical students associated with this examination; the lack of meaningful feedback provided for learning and improvement; and questions regarding the predictive ability of the exam for success or enhanced patient safety in clinical practice. The less extensive yet equally reasoned testimony in opposition to this resolution focused on the importance of physician self-regulation; maintenance of the public trust; and a concern expressed by international medical graduates (IMGs) that if this resolution is adopted, they would be held to a different, unequal standard than their U.S.-trained peers. Strong arguments were made that the responsibility for clinical skills standard should be maintained by medical schools, despite some concerns that asking schools to evaluate their own students could lead to inflated assessments through a lack of neutrality; that there could be a lack of standardization in assessments; and that not all schools had the resources to perform this particular function. These concerns were furthered by a discussion of whether the issue at hand is the nature or the cost of the examination. While acknowledging concerns, others stressed that referral would allow this important matter to be appropriately studied, and would also permit identification of a valid transition plan which could address immediate concerns of cost and lack of transparency while engaging appropriate stakeholders in the identification of concrete steps toward the return of responsibility for clinical skills assessment to the direct purview of medical schools. Your Reference Committee carefully and deliberately considered this testimony and its associated implications, and recommends adoption of the proposed resolution in lieu of the original items.

- (15) RESOLUTION 313 - ACCME PROPOSED CHANGES IN
“ACCREDITATION WITH COMMENDATION” CONTINUING MEDICAL
EDUCATION (CME) CRITERIA ASSESSMENT METHODOLOGY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 313 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study the validity, reliability and equivalency application practicality of the proposed ACCME changes in its method for assessing compliance with criteria for “Accreditation with Commendation” with a report back to the AMA House of Delegates by the 2016 Interim Meeting~~ continue to monitor the proposed Accreditation Council for Continuing Medical Education (ACCME) “Accreditation with commendation” criteria, provide input to the ACCME Board of Directors, and report to the AMA HOD once the criteria are approved and implemented.
(Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 313 be adopted as amended.

HOD ACTION: Resolution 313 adopted as amended.

Resolution 313 asks that our American Medical Association study the validity, reliability and equivalency application practicality of the proposed ACCME changes in its method for assessing compliance with criteria for “Accreditation with Commendation” with a report back to the AMA House of Delegates by the 2016 Interim Meeting

Your Reference Committee heard support for Resolution 313. The Accreditation Council for Continuing Medical Education (ACCME) has proposed new Accreditation with Commendation Criteria, and there may be changes to these criteria in late summer based on comments provided to the ACCME earlier this year. The issue is complex and requires study by the Council on Medical Education. However, these changes may impact the Council’s ability to conduct a study by November. For these reasons, your Reference Committee recommends that Resolution 313 be adopted as amended.

(16) RESOLUTION 314 - ADDICTION MEDICINE AS A MULTI-SPECIALTY SUBSPECIALTY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolve 2 in Resolution 314 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage the ABPM to offer the first ABMS-approved certification examination in addiction medicine ~~in the year 2017~~ expeditiously in order to improve access to care to treat addiction. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 314 be adopted as amended.

HOD ACTION: Resolution 314 adopted as amended.

Resolution 314 asks 1) That our American Medical Association commend the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards; and 2) That our AMA

encourage the ABPM to offer the first ABMS-approved certification examination in addiction medicine in the year 2017 in order to improve access to care to treat addiction.

Your Reference Committee heard testimony in support of Resolution 314. On March 14, the American Board of Medical Specialties (ABMS) announced the recognition of Addiction Medicine as a new subspecialty under the American Board of Preventive Medicine (ABPM). ABPM applied to the ABMS for recognition of the new subspecialty and will be the administering board for Addiction Medicine. This new subspecialty field will be open to any physician certified by any of the 24 Member Boards of the ABMS. However, no date has yet been determined for the first examination. The examination needs to be developed by experts in addiction medicine, and this process will take some time. The second resolve asks the AMA to encourage the ABPM to offer the examination in 2017, due to the large number of physicians interested in attaining certification status in addiction medicine and the pressing need for physicians to help address the opioid crisis that our nation faces. Rather than indicating a time certain, it may be more politic and appropriate to encourage development of an examination in a timely fashion, while also ensuring that the exam is well-constructed and is an accurate gauge of the qualifications of a physician to practice addiction medicine. Therefore, your Reference Committee recommends that Resolution 314 be adopted as amended.

(17) RESOLUTION 304 - EVALUATION OF FACTORS DURING RESIDENCY AND FELLOWSHIP THAT IMPACT ROUTINE HEALTH MAINTENANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 304 be referred.

HOD ACTION: Resolution 304 referred.

Resolution 304 asks that our American Medical Association study ways to improve access and reduce barriers to seeking preventive and routine physical and mental health care for trainees in graduate medical education programs.

Your Reference Committee heard significant testimony on this timely issue, as the epidemic of physician burnout and suicide continues unabated. Testimony noted the attention of our AMA to exploring and disseminating solutions, through the work of its Professional Satisfaction and Practice Sustainability strategic focus area, for example, and educational sessions on the topic (as were featured prior to the opening of this House of Delegates). Similarly, testimony was also expressed that a task force of the Accreditation Council for Graduate Medical Education is actively addressing the issues of physician burnout, wellness and resiliency. Additional testimony noted issues of confidentiality in accessing needed care, especially in smaller cities and towns; the reluctance among trainees to seek care due to fear of burdening their residency colleagues with having to cover for their absence; and the need to change the culture of medicine to enhance physician well-being and work-life balance. The Council on Medical Education testified that this resolution could be added to a planned report for the 2016 Interim Meeting on this topic, which addresses a number of resolutions referred at the Interim 2015 meeting. Accordingly, your Reference Committee recommends referral.

(18) RESOLUTION 312 - SPECIALTY BOARD REPORT CARDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 312 not be adopted.

HOD ACTION: Resolution 312 not adopted.

Resolution 312 asks 1) That our American Medical Association evaluate and prepare for distribution to the House of Delegates by the June 2017 Annual Meeting (A-17) an analysis report card comparing ABIM and NBPAS to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification); and 2) That each succeeding year the AMA evaluate and annually prepare for distribution to the House of Delegates an Analysis Report Card comparing two separate and additional specialty boards, to be selected on a rotating and inclusive basis,

from those Specialty Boards operating under the auspices of the American Board of Medical Specialties (ABMS) to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification).

Minimal testimony was offered for Resolution 312. The sponsor called on our AMA to develop a report card to evaluate certifying boards against our AMA's Principles of Maintenance of Certification (MOC). However, it was noted that the requirements for MOC are changing rapidly, so that by the time a report on an individual board could be prepared it is likely to be out of date. In addition, the specialty societies are having considerable success in achieving appropriate modification of requirements for all the steps of MOC. It was also noted that the Council on Medical Education's continued work with the American Board of Medical Specialties has helped to encourage appropriate flexibility with meeting MOC requirements. Therefore, your Reference Committee recommends that Resolution 312 not be adopted.

(19) RESOLUTION 315 - MAINTENANCE OF CERTIFICATION (MOC) AND LICENSURE (MOL) VS BOARD CERTIFICATION, CME AND LIFE-LONG COMMITMENT TO LEARNING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-275.924, H-275.926, and H-275.917 be reaffirmed in lieu of Resolution 315.

HOD ACTION: Resolution 315 referred.

Resolution 315 asks that the American Medical Association oppose discrimination by any hospital or employer, state board of medical licensure, insurers, Medicare, Medicaid, and other entities, which results in the restriction of a physician's right to practice medicine without interference (including discrimination by varying fee schedules) due to lack of recertification or participation in a Maintenance of Licensure, Maintenance of Certification program, or due to a lapse of a time-limited board certification

Your Reference Committee heard testimony in support of Resolution 315. Maintenance of Certification (MOC) is a career-long process of learning, assessment and performance improvement that is meant to demonstrate proficiency within a chosen discipline, but is separate and not required for licensure, employment or reimbursement. Your Reference Committee believes that current AMA policy covers the intent of Resolution 315. Policy H-275.924 states that the MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment. Policy H-275.926 states that our AMA 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. Policy H-275.917 states that our AMA will 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. Therefore, your Reference Committee recommends that Policies H-275.924, H-275.926, and H-275.917 be reaffirmed in lieu of Resolution 315.

Policy recommended for reaffirmation:

H-275.924, Maintenance of Certification

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 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 are neither 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. Our AMA affirms the current language regarding continuing medical education (CME): “Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 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 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. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
 12. 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. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
 14. MOC should be used as a tool for continuous improvement.
 15. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment.
 16. 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. MOC activities and measurement should be relevant to clinical practice.
 19. The MOC process should not be cost prohibitive or present barriers to patient care.
 20. Any assessment should be used to guide physicians’ self-directed study.
 21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
 22. 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.
- CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15

H-275.926, Medical Specialty Board Certification Standards

Our AMA:

1. 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. Continues 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.

Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15

H-275.917, 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 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. Our AMA will:
 - 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.

CME Rep. 3, A-15, Modified: CME Rep. 2, I-15

REPORT OF REFERENCE COMMITTEE D

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 - POWDERED ALCOHOL

RECOMMENDATION:

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

HOD ACTION: Council on Science and Public Health Report 4 adopted.

Council on Science and Public Health Report 4 examines the prevalence of excessive alcohol consumption by minors, reviews the public health concerns raised regarding powdered alcohol, and discusses actions taken by states to address these concerns. The report recommends that our American Medical Association supports federal and state laws banning the manufacture, importation, distribution, and sale of powdered or crystalline alcohol intended for human consumption.

CSAPH was thanked for their excellent review of this issue. Testimony was largely supportive of the Council's recommendations. One individual testified regarding the benefits of portability of the product. It was noted that alcohol is the most widely misused substance among America's youth. Your Reference Committee agrees with the Council's assessment regarding the potential public health harms and supports adoption of the report's recommendations.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 8 - JUVENILE JUSTICE SYSTEM REFORM

RECOMMENDATION:

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

HOD ACTION: Council on Science and Public Health Report 8 adopted.

Council on Science and Public Health Report 8 explains research findings on adolescent brain development and the impact of these findings on the juvenile justice system, discusses the impact of the use of zero tolerance policies in schools and the school-to-jail pipeline, describes the characteristics of youth involved in the juvenile justice system, explains the harms of solitary confinement, examines the evidence in support of community based alternatives, and addresses the importance of reentry and aftercare services to reduce recidivism. The report recommends that our American Medical Association:

1. Reaffirm policies H-60.922, "Solitary Confinement of Juveniles in Legal Custody," D-430.997, "Support for Health Care Services to Incarcerated Persons," and H-60.986, "Health Status of Detained and Incarcerated Youth."
2. Support school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
3. Encourage continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
4. Encourage states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
5. Support reforming laws and policies to reduce the number of youth transferred to adult criminal court.
6. Support the reauthorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (1) community-based alternatives for youth who pose little risk to public safety, (2) reentry and aftercare services to prevent recidivism, (3) policies that promote fairness to reduce

disparities, and (4) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.

7. Encourage juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
8. Encourage states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
9. Encourage Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

The Council was commended for their superb report on this difficult issue. Testimony was unanimously supportive of the Council's recommendations, which address a wide range of issues relevant to reform of the juvenile justice system. Therefore, your Reference Committee recommends adoption.

(3) RESOLUTION 402 - ADDRESSING SEXUAL ASSAULT ON COLLEGE CAMPUSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 402 be adopted.

HOD ACTION: Resolution 402 adopted.

Resolution 402 asks that our American Medical Association support universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.

Testimony was largely supportive of Resolution 402. An individual proposed the addition of a resolve to address requiring referral to law enforcement and non-university emergency departments in sexual assault cases. Opposition was heard regarding this proposal. Your Reference Committee felt that the proposed additional resolve statement was outside the scope of this resolution since it dealt with response activities rather than prevention. Since existing AMA policy does not address sexual assault prevention programs for college students, your Reference Committee recommends adoption of this resolution.

(4) RESOLUTION 403 - POLICIES ON INTIMACY AND SEXUAL BEHAVIOR IN RESIDENTIAL AGED-CARE FACILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 403 be adopted.

HOD ACTION: Resolution 403 adopted.

Resolution 403 asks that our American Medical Association urge long-term care facilities and other appropriate organizations to adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations and urge long-term care facilities and other appropriate organizations to provide staff with in-service training to develop a framework to address intimacy in their patient population.

Animated testimony was heard in support of Resolution 403. AMDA - The Society for Post-Acute and Long-Term Care Medicine indicated that they recently developed a white paper on capacity for sexual consent for people with dementia in long-term care, which is a resource for facilities on this issue. Your Reference Committee thinks this is

an important issue and recommends adoption. Given the growing prevalence of sexually transmitted diseases in the elderly population, your Reference Committee also encourages health care providers to discuss prevention with elderly patients.

(5) RESOLUTION 411 - PROTECTING CHILDREN FROM EXCESS SOUND EXPOSURE AND HEARING LOSS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 411 be adopted.

HOD ACTION: Resolution 411 adopted as amended.

RESOLVED, That our American Medical Association adopt pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour, and that toy sounds be set preferentially at 40-50 dB SPL (New HOD Policy); and be it further

RESOLVED, That our AMA work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL for more than one hour, and that toy sounds be set preferentially at 40-50 dB SPL (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss. (Directive to Take Action)

Resolution 411 asks that our American Medical Association adopt pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour, and that toy sounds be set preferentially at 40-50 dB; work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL for more than one hour, and that toy sounds be set preferentially at 40-50 dB SPL; and work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.

Testimony was largely supportive of Resolution 411. Since existing AMA policy does not address specific pediatric noise exposure standards, your Reference Committee recommends adoption of this resolution. There were concerns raised that noise and hearing loss should be addressed as an issue across the lifespan. Since this is outside the intent of the original resolution, your Reference Committee recommends that this resolution be adopted and encourages future resolutions to address these additional concerns.

(6) RESOLUTION 422 - SUNSCREEN USE AT SCHOOLS AND SUMMER CAMPS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 422 be adopted.

HOD ACTION: Resolution 422 adopted.

Resolution 422 asks that our American Medical Association work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.

Testimony was largely supportive of Resolution 422. Limited testimony raised concerns regarding dermatitis-based allergic reactions to sunscreens in certain individuals. Given the increasing prevalence of skin cancer and the current restrictions placed on sunscreens in schools and daycares, your Reference Committee recommends adoption.

(7) RESOLUTION 430 - SUPPORT FOR DETERGENT POISONING AND CHILD SAFETY ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 430 be adopted.

HOD ACTION: Resolution 430 adopted.

Resolution 430 asks that our American Medical Association advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements; are manufactured to be less attractive to children in color and in design; include conspicuous warning labels; and that the product package labeling be constructed in a clear and obvious method so children know that the product is dangerous to ingest.

Testimony was unanimously supportive of Resolution 430. Given the harms associated with laundry detergent packets and the limited success of voluntary efforts to address these harms, your Reference Committee agrees that the resolution should be adopted.

(8) RESOLUTION 404 - VACCINE AVAILABILITY IN SMALL PRACTICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 404 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 404 be changed.

VACCINE AVAILABILITY IN SMALL QUANTITIES

HOD ACTION: Resolution 404 adopted with a change in title.

Resolution 404 asks that our American Medical Association encourage vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

Testimony on Resolution 404 was largely supportive of this resolution. One individual suggested referral to study other vaccine universal purchasing mechanisms in place in some jurisdictions. However, given the widespread agreement that the inability of physician practices to purchase small quantities of vaccine is a barrier to immunizations, your Reference Committee supports adoption.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - CSAPH SUNSET REVIEW OF 2006 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be amended by addition to read as follows:

The Council on Science and Public Health recommends that the House of Delegates directives and policies that are listed in the Appendix to this report be acted upon in the manner indicated in the Appendix, with the exception of D-120.969 and the remainder of the report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 1 be amended by the addition of a new Recommendation 2 to read as follows:

That Policy D-120.969 in Council on Science and Public Health Report 1 be retained.

RECOMMENDATION C:

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

HOD ACTION: Council on Science and Public Health Report 1 adopted as amended.

Council on Science and Public Health Report 1 presents the Council's recommendations on the disposition of the House policies from 2006 that were assigned to it. The report recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Limited testimony was heard on the Council's sunset report. Testimony was heard in support of retaining existing policy on hormone replacement until the Council completes its pending report on this issue. The Council had no objection to the proposed change. Your Reference Committee supports retaining this policy until after that report is released.

(10) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 6 - DELAYING SCHOOL START TIME TO PREVENT ADOLESCENT SLEEP DEPRIVATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Science and Public Health Report 6 be amended by addition to read as follows:

Encourage physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Council on Science and Public Health Report 6 adopted as amended.

Council on Science and Public Health Report 6 reviews the health and academic consequences of decreased sleep in adolescents and examines recent evidence for delaying school start times as a mechanism to address adolescent sleep deprivation. The report recommends that our American Medical Association: (1) encourage school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (2) encourage physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the sleep needs of adolescents; (3) reaffirm policy H-60.930, Insufficient Sleep in Adolescents, identifying adolescent insufficient sleep and sleepiness as a public health issue and supporting education about sleep health as a standard component of care for adolescent patients; and (4) encourage continued research on the impact of sleep on adolescent health and academic performance.

In testimony, the Council on Science and Public Health was praised for its report on the issue of adolescent sleep. While there was some acknowledgment regarding the potential burden a later start time may have on families, there was recognition of the important role that exists for physicians to use this paper with their own local school boards. The AAP recommended adding the word “biologic” to stress that more sleep is a biological need not just a preference. The Council supported the amendment and so did your Reference Committee.

(11) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 7 -
PREVENTING VIOLENT ACTS AGAINST HEALTH CARE PROVIDERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 5 in Council on Science and Public Health Report 7 be amended by addition to read as follows:

5. Amend Policy H-215.978, “Guns in Hospitals,” by addition and deletion and a change in title to better reflect the content of the policy to read as follows:

Workplace Violence Prevention

Our AMA:

(1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups’ collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; (2) encourages physicians to work with their hospital safety committees to address the security issues within particular hospitals; ~~and also~~ encourages physicians to become aware of and familiar with their own institution’s policies and procedures; and encourages physicians to participate in training to prevent and respond to workplace violence threats; encourages physicians to report all incidents of workplace violence; and encourages physicians to promote a culture of safety within their workplace; and (3) urges that hospital safety committees include physicians and that emergency departments be recognized as high risk environments for violence. (Modify Current HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Council on Science and Public Health Report 6 adopted as amended.

Council on Science and Public Health Report 7 provides information on the incidence of workplace violence in the health care setting, outlines the landscape of requirements for employers to protect health care workers from violence, and reviews the interventions to prevent workplace violence in the health care setting and the evidence of their effectiveness. The report recommends that our American Medical Association:

1. Encourage the Occupational Safety and Health Administration to develop and enforce a standard addressing workplace violence prevention in health care and social service industries.
2. Encourage Congress to provide additional funding to the National Institute for Occupational Safety and Health to further evaluate programs and policies to prevent violence against health care workers.
3. Encourage the National Institute for Occupational Safety and Health to adapt the content of their online continuing education course on workplace violence for nurses into a continuing medical education course for physicians.
4. Amend Policy H-515.966, "Violence and Abuse Prevention in the Health Care Workplace," by addition and deletion to read as follows: Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; and develop policies to assess and manage reported occurrences of workplace violence and abuse; and will advocate that make training courses on workplace violence prevention available to employees and consultants and reduction be more widely available; and include physicians in safety and health committees.
5. Amend Policy H-215.978, "Guns in Hospitals," by addition and deletion and a change in title to better reflect the content of the policy to read as follows:

Workplace Violence Prevention

Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; (2) encourages physicians to work with their hospital safety committees to address the security issues within particular hospitals; ~~and also encourages physicians to become aware of and familiar with their own institution's policies and procedures;~~ encourages physicians to participate in training to prevent and respond to workplace violence threats; encourages physicians to report all incidents of workplace violence; and encourages physicians to promote a culture of safety within their workplace. ~~and (3) urges that hospital safety committees include physicians and that emergency departments be recognized as high risk environments for violence.~~

6. Amend Policy D-515.983, "Preventing Violent Acts Against Healthcare Providers," by addition and deletion to read as follows (as it has been implemented in part):
 1. Our AMA will ~~make CSAPH Report 2-I-10, Violence in the Emergency Department, available to hospitals, emergency medicine departments, emergency physicians, mental health physicians, patient advocates, and law enforcement organizations as a resource designed to assist in the implementation of procedures to protect students, trainees, physicians, nurses, and other health care staff in the Emergency Department environment and to assure optimal care for patients, including those with psychiatric or behavioral conditions.~~ 2. Our American Medical Association will: (a) continue to work with other appropriate organizations to study mechanisms to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training the results of this study.

The Council on Science and Public Health was commended for increasing awareness regarding this important issue. Strong support was heard in support of the Council's recommendations. Your Reference Committee received testimony from the Emergency Medicine Section Council asking to retain language regarding emergency departments being recognized as high risk environments for violence. Your Reference Committee agrees that this policy should be retained.

(12) RESOLUTION 401 - EVIDENCE-BASED SEXUAL EDUCATION ENFORCEMENT IN SCHOOL

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage physicians and all interested parties to develop best-practice, evidence-based, guidelines for ~~developmentally appropriate~~ sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 401 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 401 be changed to read as follows:

EVIDENCE-BASED SEXUAL EDUCATION IN SCHOOLS

HOD ACTION: Resolution 401 adopted as amended with a change in title.

Resolution 401 asks that our American Medical Association encourage all interested parties to develop best-practice, evidence-based guidelines for developmentally appropriate sexual education curricula that are medically, factually, and technically accurate.

Testimony on Resolution 401 was supportive of evidence-based sexual curricula. Existing policy supports comprehensive, developmentally appropriate education programs that are based on rigorous peer-reviewed science and supports the redirection of federal resources for the development and dissemination of comprehensive sex education programs. The intent of this resolution was to ensure engagement of physicians in the development of evidence-based sexual education curriculum. To meet the intent of this resolution, your Reference Committee felt it was warranted to explicitly include physicians. Enforcement was removed from the title to better reflect the scope of the resolution.

(13) RESOLUTION 405 - SEXUAL VIOLENCE EDUCATION AND PREVENTION IN HIGH SCHOOLS WITH SEXUAL HEALTH CURRICULA

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 405 be amended by deletion to read as follows:

H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools

Our AMA:(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate

sexual violence prevention; ~~(b)~~(c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; ~~(e)~~ (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; ~~(d)~~ (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; ~~(e)~~ (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and ~~(f)~~ (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence and reduce substance use while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships , sexual health, and conversations about consent and substance abuse.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 405 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 405 be changed.

SEXUAL VIOLENCE EDUCATION AND PREVENTION IN SCHOOLS

HOD ACTION: Resolution 405 adopted as amended with a change in title.

Resolution 405 asks that our American Medical Association amend Policy H-170.968 by addition and deletion to read as follows:

H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools

Our AMA:(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; ~~(b)(c)~~ show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; ~~(c)~~ (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; ~~(d)~~ (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; ~~(e)~~ (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and ~~(f)~~ (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence and reduce substance use while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, conversations about consent and substance abuse.

Testimony was overwhelmingly supportive of Resolution 405. Current AMA policy on sexual education does not currently address sexual violence. Testimony asked that amendments referencing substance abuse be removed. Your Reference Committee agrees and recommends adoption as amended.

(14) RESOLUTION 406 - RESEARCH THE EFFECTS OF PHYSICAL OR VERBAL VIOLENCE BETWEEN LAW ENFORCEMENT OFFICERS AND PUBLIC CITIZENS ON PUBLIC HEALTH OUTCOMES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 406 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 406 be amended by the addition of a second Resolve to read as follows:

RESOLVED, That our American Medical Association affirm that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 406 be amended by addition of a third Resolve to read as follows.

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention as well as state and local health departments and agencies to research the nature and public health implications of violence involving law enforcement.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 406 be adopted as amended.

HOD ACTION: Resolution 406 adopted as amended.

Resolution 406 asks that our American Medical Association study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.

Testimony on Resolution 406 was supportive of the need for additional information on the public health outcomes of violence between law enforcement officers and public citizens, particularly racial and ethnic minorities. However, there is currently limited evidence linking law enforcement violence to public health outcomes, making this a difficult issue for our AMA to study. Your Reference Committee heard testimony indicating that the Roundtable on Population Health of the National Academies of Sciences, Engineering, and Medicine is holding a workshop on community violence as a population health issue and therefore felt it was best to amend this resolution asking the National Academies to study this issue. Support was also heard for two additional resolve statements recognizing violence between law enforcement and public citizens as a social determinant of health and encouraging additional research across the public health enterprise. Your Reference Committee supports the addition of these resolves.

(15) RESOLUTION 407 - TOBACCO PRODUCTS IN PHARMACIES AND HEALTHCARE FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-495.977 be amended by addition and deletion to read as follows:

Banning the Sale of Tobacco Products in Pharmacies and Health Care Facilities and/or Tobacco By Products in Retail Outlets Housing Store Based Health Clinics

Our AMA supports efforts to ban the sale of tobacco products ~~and/or tobacco by products~~ meeting the definition of "tobacco product" under the Family Smoking Prevention and Tobacco Control Act, with the exception of medicinal nicotine products approved by the FDA, where health care is delivered or where prescriptions are filled, including retail outlets housing store-based health clinics.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-495.977 be adopted in lieu of Resolution 407.

HOD ACTION: Amended Policy H-495.977 adopted in lieu of Resolution 407.

Resolution 407 asks that our American Medical Association support the position that the sale of any tobacco or vaporized nicotine products be prohibited where healthcare is delivered or where prescriptions are filled.

Your Reference Committee heard testimony in support of the intent of Resolution 407. However, because vaporized nicotine products could include medicinal products approved by the FDA, such as the nicotine inhaler, your Reference Committee thought it would be best to amend existing policy to include “tobacco products” as defined under the Family Smoking Prevention and Tobacco Control Act. Products that meet the statutory definition of “tobacco products” include, but are not limited to, currently marketed products such as dissolvables not already regulated by FDA, gels, waterpipe tobacco, electronic nicotine delivery systems (including e-cigarettes, e-hookah, e-cigars, vape pens, advanced refillable personal vaporizers, and electronic pipes), cigars, and pipe tobacco.

- (16) RESOLUTION 409 - LEAD AND COPPER RULE COMPLIANCE
 RESOLUTION 413 - BAN LEAD IN PLUMBING
 RESOLUTION 414 - REPLACE MUNICIPAL LEAD PLUMBING
 RESOLUTION 415 - REGULAR MONITORING OF WATER AT SCHOOL AND DAYCARE SITES
 RESOLUTION 416 - TIMELY AND TRANSPARENT DATA SHARING FOR DRINKING WATER TESTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 409, 413, 414, 415, and 416.

SAFE DRINKING WATER

RESOLVED, That our AMA supports updates to the U.S. Environmental Protection Agency’s Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:

- (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;
- (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
- (3) Informing consumers about the health-risks of partial lead service line replacement;
- (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
- (5) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;
- (6) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations; and
- (7) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead.

HOD ACTION: Alternative Resolution 409 adopted as amended in lieu of Resolutions 409, 413, 414, 415, and 416.

8) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act (Directive to take action).

Resolution 409 asks that our American Medical Association work with the Environmental Protection Agency to shorten and streamline the Lead and Copper Rule compliance deadline requirements in the Safe Drinking Water Act with the goal of avoiding unnecessary multi-year periods and other prolonged compliance deadlines, while maintaining reasonableness in review of circumstances on a case-by-case basis.

Resolution 413 asks that our American Medical Association pursue lead-free standards at the federal level that are actually lead-free, for all plumbing related to drinking water.

Resolution 414 asks that our American Medical Association strongly advocate that the United States of America end the man-made scourge of lead in drinking water by taking swift action to support the replacement of lead plumbing throughout our country.

Resolution 415 asks that our American Medical Association lobby at the federal level for the following mandates: (1) that all schools and registered daycare sites be among those sites routinely chosen by municipal water quality assurance testing as part of the Safe Drinking Water Act enforcement; and (2) in cases where there are abnormal test results from water testing at schools and registered daycare sites, that those sites continue to be tested repeatedly until results return to normal.

Resolution 416 asks that our American Medical Association lobby at the federal level for legislation, regulations, and/or policies that would: (1) require all municipal water test results performed by municipal, city, county, district or state agencies to be posted on a publicly available website within seven business days of their receipt; (2) require all communicable disease reports performed by city, county, district or state agencies to be posted on a publicly available website within seven business days of their receipt; (3) require reports of sewage overflows to be posted on a publicly available website within four hours of the receipt of such reports; (4) create and make available a real-time alert system for all water test results, which exceed federal, state, or local standards within a person's designated zip code(s), to which the public could subscribe; and (5) create and make available a process in which all collected test results related to the quality of water that are excluded from final data analysis are annotated and explained.

Your Reference Committee heard overwhelming support for the intent of Resolutions 409, 413, 414, 415 and 416 in response to the contamination of drinking water in Flint, MI. There was some support for referral of these resolutions for further study. The Council of Science and Public Health proposed a substitute resolution that addresses the gaps in the Lead and Copper Rule and captures the intent of all the proposed resolutions. Your Reference Committee recommends adoption of this comprehensive substitute resolution.

(17) RESOLUTION 410 - BABY-FRIENDLY HEALTH CARE DELIVERY AND BREASTFEEDING RIGHTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 410 be deleted.

~~RESOLVED, That our American Medical Association adopt policy that supports the implementation of the full ten steps of the World Health Organization (WHO) Baby Friendly Hospital Initiative in all sites of health care delivery (New HOD Policy); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 410 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA adopt policy supporting the evaluation and grading of the practice of primary care interventions to support breastfeeding as an~~

~~intervention~~, as developed by the United States Preventive Services Task Force (USPSTF). (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 410 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 410 be changed.

PRIMARY CARE INTERVENTIONS TO SUPPORT BREASTFEEDING

HOD ACTION: Resolution 410 adopted as amended with a change in title.

Resolution 410 asks that our American Medical Association adopt policy that supports the implementation of the full ten steps of the World Health Organization Baby-Friendly Hospital Initiative in all sites of health care delivery and adopt policy supporting the evaluation and grading of the practice of breastfeeding as an intervention, as developed by the United States Preventive Services Task Force.

Your Reference Committee heard conflicting testimony regarding Resolution 410. Some concerns were raised regarding new evidence that conflicts with some of the Baby Friendly Health Initiative (BFHI) recommendations. Testimony also highlighted that patient satisfaction has decreased in some hospitals with the BFHI designation. Support was heard for the USPSTF grading of interventions to support breastfeeding. There was overwhelming testimony in support of deleting the first resolve. Therefore, your Reference Committee recommends adoption of the resolution as amended.

(18) RESOLUTION 418 - CHALLENGING THE PRO-TOBACCO ACTIONS OF THE U.S. CHAMBER OF COMMERCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 418 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association strongly object to any pro-tobacco efforts by the U.S. Chamber of Commerce ~~in other nations~~ and encourage ~~call upon~~ the U.S. Chamber of Commerce to be transparent in ~~immediately halt~~ all advocacy activity on behalf of tobacco companies.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 418 be deleted.

~~RESOLVED, That our AMA urge conscientious companies that are members of the U.S. Chamber of Commerce to call for an end to all pro-tobacco efforts within the organization, and if necessary, quit their membership to protest such anti-health activity.~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 418 be adopted as amended.

HOD ACTION: Resolution 418 adopted as amended.

RESOLVED, That our American Medical Association strongly object to any pro-tobacco efforts by the U.S. Chamber of Commerce ~~in other nations~~ and encourage call upon the U.S. Chamber of Commerce to be transparent in immediately halt all advocacy activity on behalf of tobacco companies.

RESOLVED, That our AMA urge conscientious companies that are members of the U.S. Chamber of Commerce to call for an end to all pro-tobacco efforts within the organization.

Resolution 418 asks that our American Medical Association strongly object to any pro-tobacco efforts by the U.S. Chamber of Commerce in other nations and call upon the U.S. Chamber of Commerce to immediately halt all advocacy activity on behalf of tobacco companies and urge conscientious companies that are members of the U.S. Chamber of Commerce to call for an end to all pro-tobacco efforts within the organization, and if necessary, quit their membership to protest such anti-health activity.

Testimony was heard both in support of and in opposition to Resolution 418. Your Reference Committee agrees with the public health concerns raised by the advocacy activities conducted by the U.S. Chamber of Commerce on tobacco issues. However, given the chambers interest in advocating on behalf of their members, your Reference Committee felt that rather than the AMA advocating for organizations to quit their membership in the chamber, the AMA should encourage the chamber to be transparent in their advocacy efforts so organizations can make an informed decision regarding their membership.

(19) RESOLUTION 419 - OPPOSITION TO QUARANTINE FOR ZIKA PATIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 419 be amended by addition to read as follows:

RESOLVED, That our American Medical Association oppose quarantine measures for suspected-Zika-infected patients. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 419 be adopted as amended.

HOD ACTION: Resolution 419 adopted.

Resolution 419 asks that our American Medical Association oppose quarantine measures for Zika-infected patients.

Testimony was heard in support of Resolution 419. Zika is a vector-borne disease that can also be sexually transmitted. There is widespread agreement in the scientific community that quarantine will not be effective in controlling the spread of Zika virus. Your Reference Committee felt that it was important to develop policy in support of science-based quarantine measures.

(20) RESOLUTION 420 - CREATE A CONTINGENCY FUND AT CDC TO FACILITATE TIMELY RESPONSE TO PUBLIC HEALTH THREATS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 420 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the reauthorization establishment and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services of a contingency fund at CDC to facilitate adequate responses to future public health emergencies without redistributing funds from established public health accounts. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 420 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 420 be changed.

FUND FOR PUBLIC HEALTH EMERGENCY RESPONSE

HOD ACTION: Resolution 420 adopted as amended with a change in title.

Resolution 420 asks that our American Medical Association support establishment of a contingency fund at CDC to facilitate adequate responses to future public health emergencies.

Your Reference Committee heard testimony in support of the concept of this resolution given the delay by Congress in approving the emergency supplemental funding for the Zika virus response. Congress authorized the establishment of Public Health Emergency Fund in 1983, but has not regularly appropriated funding to this account. Minor amendments were made to reflect that this fund may not be specifically defined as a “contingency” fund and that while the fund will likely be administered by the Department of Health and Human Services, it may not be specifically under the CDC. Some members of the Reference Committee raised issues regarding the process of creating such an account, but overall your Reference Committee felt that it was important to appropriate funding for public health emergencies without redistributing funds from existing public health accounts.

- (21) RESOLUTION 424 - ENHANCED ZIKA VIRUS PUBLIC HEALTH ACTION
– NOW
RESOLUTION 431 – FUNDING FOR ZIKA CONTROL AND RESEARCH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 424 be amended by substitution to read as follows:

RESOLVED, That our American Medical Association urge Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 424 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage the Centers for Disease Control and Prevention to continue working with experts in all relevant disciplines, and

convene expert workgroups when appropriate, to help develop needed ~~American~~ U.S. and global strategies and limit the spread and impact of this virus (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 424 be amended by deletion to read as follows:

RESOLVED, That our AMA consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to ~~develop and~~ promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 424 be adopted as amended in lieu of Resolution 431.

HOD ACTION: Resolution 424 adopted as amended in lieu of Resolution 431.

RESOLVED, That our American Medical Association urge Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives. (Directive to Take Action)

RESOLVED, That our AMA work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed ~~American~~ United States and global strategies and limit the spread and impact of this virus (Directive to Take Action)

RESOLVED, That our AMA consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to ~~develop and~~ promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women. (Directive to Take Action)

Resolution 424 asks that our American Medical Association immediately increase its advocacy efforts for adequate Federal and state support for Zika virus control and research—including vector and pathogenesis research, vaccine development, environmental and vector controls, targeted Zika testing and treatment, patient education, public education, and the notification and education of those who may have been exposed to Zika viruses sexually or by mosquitoes; work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed American and global strategies and limit the spread and impact of this virus; and consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to develop and promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.

Resolution 431 asks that our American Medical Association urge Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus commensurate with the public health emergency that the virus poses without diverting resources from other essential health initiatives.

Your Reference Committee heard testimony in support of Resolutions 424 and 431. Testimony strongly encouraged the AMA to strengthen their lobbying efforts in support of Zika funding and to not lead from behind on this important issue that can have devastating consequences for pregnant women and their babies. Your Reference

Committee felt that CDC was the appropriate organization to convene relevant stakeholders on this issue given the Zika Action Plan Summit they held in April, that the AMA attended, and the regular follow-up conference calls they have subsequently held. Your Reference Committee also recognizes that educational resources already exist around strategies to minimize transmission of Zika virus, and that the AMA should not reinvent the wheel, but promote these existing resources. Your Reference Committee recognizes the importance of this issue and therefore recommends this resolution be adopted as amended.

(22) RESOLUTION 425 - OPPOSE EFFORTS TO STOP, WEAKEN OR DELAY
FDA'S AUTHORITY TO REGULATE ALL TOBACCO PRODUCTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 425 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage Congress to oppose any legislation that would stop, weaken, or delay FDA's authority to fully regulate all tobacco products. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends the addition of a second Resolve to read as follows:

RESOLVED, That our American Medical Association write a letter to the Administration expressing our strong opposition to the decision to strike from the Food and Drug Administration's deeming rule on tobacco products, the restriction of flavored electronic nicotine delivery systems. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 425 be adopted as amended.

HOD ACTION: Resolution 425 adopted as amended.

Resolution 425 asks that our American Medical Association oppose any legislation that would stop, weaken or delay FDA's authority to fully regulate all tobacco products. Your Reference Committee heard testimony on the need to communicate to Congressional leaders the strong opposition to the recent decision to strike provisions to regulate candy flavored e-cigarettes from the FDA Final Deeming Rule. Your Reference Committee recommends adoption as amended.

Testimony was heard in support of referral of this resolution. CSAPH spoke against referral given their recent reports addressing this issue. Amendments were proposed to address the issue of restricting the sale of flavored electronic nicotine delivery systems, which was originally proposed, but removed from the final version of the FDA's new deeming rule on tobacco products. Your Reference Committee supports adoption of Resolution 425 as amended.

(23) RESOLUTION 426 - WEAPONS, HOSPITAL WORKPLACE AND PATIENT
SAFETY ISSUES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolve 1 - 4 of Resolution 426 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate that hospitals and other healthcare delivery settings ~~restrict~~ limit guns and ~~conducted electrical weapons TASERS on their premises, particularly in emergency departments and psychiatric in units~~ where patients suffering from mental illness are present (New HOD Policy)

~~RESOLVED, That our AMA reaffirm Policy H 145.975 and support Joint Commission's position which strongly encourages its accredited institutions to report "sentinel events" defined as patient safety events that result in "death, permanent harm, or severe temporary harm and intervention necessary to sustain life" (Reaffirm HOD Policy); and be it further~~

~~RESOLVED, That our AMA encourage all hospitals to invest in comprehensive training of security personnel that focus on patient safety, empathy, and de-escalation (New HOD Policy); and be it further~~

~~RESOLVED, That our AMA advocate for increased resources and broader efforts to work with partner organizations, such as the National Alliance on Mental Health, to increase awareness, access, and education to de-stigmatize mental health among minority communities. (New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policies H-345.974, H-145.975, H-215.977 be reaffirmed.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 426 be adopted as amended.

HOD ACTION: Resolution 426 adopted as amended.

Resolution 426 asks that our American Medical Association advocate that hospitals and other healthcare delivery settings restrict guns and Tasers on their premises, particularly in emergency departments and psychiatric units where patients suffering from mental illness are present; reaffirm Policy 145.975 and support Joint Commission's position which strongly encourages its accredited institutions to report "sentinel events" defined as patient safety events that result in "death, permanent harm, or severe temporary harm and intervention necessary to sustain life"; encourage all hospitals to invest in comprehensive training of security personnel that focus on patient safety, empathy, and de-escalation; and advocate for increased resources and broader efforts to work with partner organizations, such as the National Alliance on Mental Health, to increase awareness, access, and education to de-stigmatize mental health among minority communities.

Your Reference Committee heard passionate testimony in support of the spirit of the resolution. Testimony favored developing policy with less restrictive language regarding guns and conducted electrical weapons would allow for health care settings to implement policies that they deemed appropriate. Testimony also stated support for reaffirmation of existing AMA polices that accomplish some of the Resolves of this Resolution. AMA has existing policy calling for training to recognize and defuse potentially violent situations and access to mental health services for diverse, multi-ethnic communities. Therefore, your Reference Committee recommends adoption as amended and reaffirmation of stated policies.

Policies for Reaffirmation:

H-345.974, Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities
Our AMA supports adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk, and encourages greater

cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates, and respected media outlets.

H-145.975, Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

H-215.977, Guns in Hospitals

The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention: (1) Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted. (2) The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs. (3) Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel. (4) Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included. (5) Policies should undergo periodic reassessment and evaluation. (6) Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

(24) RESOLUTION 427 - COMMUNITY BENEFIT DOLLARS FOR DIABETES PREVENTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 427 be amended by addition of a Resolve to read as follows:

RESOLVED, That our AMA encourage that private and public payors offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 427 be adopted as amended.

HOD ACTION: Resolution 427 adopted as amended.

Resolution 427 asks that our American Medical Association support allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program; work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program with community benefit dollars; and encourage each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients.

Given the prevalence of diabetes and pre-diabetes, testimony was in support of the intent of the resolution. Your Reference Committee also heard testimony asking for the addition of payors to the resolution to encourage them to provide coverage for the diabetes prevention program. Your Reference Committee recommends the addition of a resolve to address this issue.

(25) RESOLUTION 428 - LEAD CONTAMINATION IN FLINT WATER:
NEGLIGENCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 428 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for ~~the children of Flint who are~~ exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 428 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for appropriate nutritional support for all ~~Flint residents~~ people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. ~~That s~~Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 428 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA promote screening, diagnosis and acceptable treatment of lead exposure and iron deficiency ~~anemia~~ in all people Flint residents exposed to lead contaminated water, ~~especially women and children.~~ (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 428 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 428 be changed.

LEAD CONTAMINATION IN MUNICIPAL WATER SYSTEMS AS EXEMPLIFIED BY FLINT, MICHIGAN

HOD ACTION: Resolution 428 adopted as amended with a change in title.

Resolution 428 asks that our American Medical Association advocate for hematological and neurodevelopmental monitoring at established intervals for the children of Flint who are exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure; urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL; advocate for appropriate nutritional support for all Flint residents, but especially exposed pregnant women, lactating mothers and exposed children. That support should include Vitamin C, green leafy vegetables and other calcium sources so that their bodies will not be forced to substitute lead for missing calcium as the children grow; and promote screening, diagnosis and treatment of lead exposure and iron deficiency anemia in all Flint residents, especially women and children.

Testimony was largely supportive of Resolution 428. There was agreement regarding the need for ongoing monitoring of the health of the children in Flint. Your Reference Committee heard that Flint was the tip of the iceberg on lead drinking water exposure and that the resolution needs to be expanded to encompass all exposed to lead contaminated water. Your Reference Committee recommends adoption as amended with a title change.

(26) RESOLUTION 429 - APPROPRIATE LABELING OF SLEEP PRODUCTS FOR INFANTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that following resolution be adopted in lieu of Resolution 429.

HOD ACTION: Alternative Resolution 429 adopted in lieu of Resolution 429.

RESOLVED, That our American Medical Association advocate for the appropriate labeling of all infant sleep products, not in compliance with the Safe Infant Sleeping Environment Guidelines, as adopted by the AAP, to adequately warn consumers of the risks of product use and prevent sudden unexpected infant death; (New HOD Policy) and be it further

RESOLVED, That our AMA encourage consumers to avoid commercial devices marketed to reduce the risk of SIDS, including: wedges, positioners, special mattresses, and special sleep surfaces; (New HOD Policy) and be it further

RESOLVED, That our AMA encourage media and manufacturers to follow safe-sleep guidelines in their messaging and advertising (New HOD Policy).

Resolution 429 asks that our American Medical Association adopt the following excerpted guidelines of the Safe Infant Sleeping Environment Guidelines adapted from the American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC), which read as follows: (1) "Avoid commercial devices marketed to reduce

the risk of SIDS. These devices include wedges, positioners, special mattresses, and special sleep surfaces. There is no evidence that these devices reduce the risk of SIDS or suffocation or that they are safe” and (2) “Media and manufacturers should follow safe-sleep guidelines in their messaging and advertising.”; advocate for the appropriate labeling of all infant sleep products that are not in compliance with the American Academy of Pediatrics and the CDC “Safe Infant Sleeping Environment Guidelines” to adequately warn consumers of the risks of product use. “Media and manufacturers should follow safe-sleep guidelines in their messaging and advertising.”; and advocate on the state and federal level for the appropriate labeling of all infant sleep products that are not in compliance with the American Academy of Pediatrics and the CDC Safe Infant Sleeping Environment Guidelines to adequately warn consumers of the risks of product use.

Your Reference Committee heard testimony supportive of Resolution 429. Your Reference Committee felt that the language as proposed in the original resolution could be streamlined while still maintaining the intent of the original resolution, which was to support consumers’ awareness of the risks associated with the use of commercial devices marketed to reduce the risk of SIDS and Sudden Unexpected Infant Death. Since existing AMA policy does not address appropriate labeling of sleep products for infants, your Reference Committee recommends adoption of this resolution as amended.

(27) RESOLUTION 417 - CHANGING PUBLIC POLICY TO ASSIST OBESITY GOALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 417 be referred.

HOD ACTION: Resolution 417 referred.

Resolution 417 asks that our American Medical Association support efforts to limit the consumption of foods and beverages that contain added sweeteners, including but not limited to, ending corn subsidies for the production of high fructose corn syrup.

Your Reference Committee heard testimony in support of Resolution 417. CSAPH noted that current AMA policy recognizes there is insufficient evidence to recommend restricting the use of high fructose corn syrup and other fructose-containing sweeteners. The CSAPH is working on a related report for I-16 and asked that this item be referred to allow for a review of the available scientific evidence. Your Reference Committee agrees with CSAPH that this item be referred for further study.

(28) RESOLUTION 421 - RATIONAL REGULATION OF ELECTRONIC NICOTINE DELIVERY SYSTEMS (ENDS)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 421 not be adopted.

HOD ACTION: Resolution 421 not adopted.

Resolution 421 asks that our American Medical Association oppose measures that would have the practical effect of imposing more burdensome regulatory burdens on electronic nicotine delivery systems (ENDS) than on more hazardous combustible cigarettes; oppose measures that would have the practical effect of making cigarette companies the dominant manufacturers and marketers of ENDS products; and oppose measures that would have the practical effect of eliminating ENDS from the U.S. market as long as combustible cigarettes are marketed to, and smoked by, a significant proportion of Americans.

Testimony was heard in strong opposition to this resolution, which has the practical effect of opposing the FDA’s regulatory authority over all tobacco products. The AMA has strong policy in support of the FDA regulation of all tobacco products, including ENDS. In written testimony the FDA indicated that this resolution is based on

inaccurate information regarding the pre-market tobacco application requirements and costs. According to the U.S. Preventive Services Task Force, there is insufficient evidence to recommend ENDS for tobacco cessation. Therefore, your Reference Committee recommends that Resolution 421 not be adopted.

(29) RESOLUTION 423 - CORE MEASURE FOR FLU VACCINATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 423 not be adopted.

HOD ACTION: Resolution 423 not adopted.

Resolution 423 asks that our American Medical Association study the benefits and risks of systematically administering flu vaccinations to post-operative patients in the hospital setting, with report back at the 2016 Interim Meeting.

Your Reference Committee heard mixed testimony on this Resolution. Testimony from the Council on Science and Public Health noted that this would be a difficult issue for the AMA to study given that we do not have the appropriate data to conduct such a study. The Council also noted that a study was recently published in the *Annals of Internal Medicine* examining this issue, which found no strong evidence of increased risk for adverse outcomes in comparing patients who received vaccination during hospitalization and those who did not. Given that this issue has already been studied, your Reference Committee recommends that Resolution 423 not be adopted.

REPORT OF REFERENCE COMMITTEE E

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 - HUMAN AND ENVIRONMENTAL EFFECTS OF LIGHT EMITTING DIODE (LED) COMMUNITY LIGHTING

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: Council on Science and Public Health Report 2 adopted.

Council on Science and Public Health Report 2 reviews the health and environmental effects of LED community lighting, and makes recommendations to advise communities on selecting among LED lighting options that minimize potentially harmful human health and environmental effects. It recommends that our American Medical Association (AMA) (1) support the proper conversion to community based Light Emitting Diode (LED) lighting, which reduces energy consumption and decreases the use of fossil fuels; (2) encourage minimizing and controlling blue-rich environmental lighting by using the lowest emission of blue light possible to reduce glare; and (3) encourage the use of 3000K or lower lighting for outdoor installations such as roadways. All LED lighting should be properly shielded to minimize glare and detrimental human and environmental effects, and consideration should be given to utilize the ability of LED lighting to be dimmed for off-peak time periods.

Limited but supportive testimony was offered for this report. The Council was acknowledged for providing a science-based view of this topic, which can be used as a resource for communities undertaking the process to replace their lighting with LED-type options. Testimony also noted the important historical role of the Council in advancing understanding of the light pollution issue and favorably influencing company policies.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - THE PRECISION MEDICINE INITIATIVE

RECOMMENDATION:

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

HOD ACTION: Council and Science and Public Health Report 3 adopted.

Council on Science and Public Health Report 3 informs physicians and the House of Delegates about the Precision Medicine Initiative and the potential ways that it could affect their practice and their patients. It recommends that our American Medical Association (1) work with the Precision Medicine Initiative (PMI) to gather input from physicians to assist in the planning stages of the initiative and to improve awareness and willingness to recruit patients as participants; (2) encourage the PMI to develop resources that will assist physicians in understanding the goals of the PMI, how to recruit and enroll patients, and how to best use the research results generated by it; and (3) continue to advocate for improvements to electronic health record systems that will enable interoperability and access while not creating additional burdens and usability challenges for physicians.

Testimony thanked the Council for an excellent report summarizing the Precision Medicine Initiative (PMI) for the House of Delegates, and supported the Council's recommendations. It was stressed that precision medicine is the future of medicine, and that our AMA should vigorously support education for physicians who will encounter patients interested in participating in the PMI. Your Reference Committee recommends that the Council's recommendations be adopted.

- (3) RESOLUTION 503 - COST-EFFECTIVE TECHNOLOGIES AS A SOLUTION TO WANDERING PATIENTS WITH ALZHEIMER'S DISEASE AND OTHER RELATED DEMENTIAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 503 be adopted.

HOD ACTION: Resolution 503 adopted.

Resolution 503 asks that our American Medical Association support the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations.

Limited but overwhelmingly supportive testimony for adoption of this resolution highlighted the importance of using technologies as solutions for finding wandering Alzheimer's and other related dementia patients. Your Reference Committee concurs, and recommends adopting Resolution 503.

- (4) RESOLUTION 509 - KRATOM AND ITS GROWING USE WITHIN THE UNITED STATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 509 be adopted.

HOD ACTION: Resolution 509 adopted.

Resolution 509 asks that our American Medical Association support legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.

Testimony was limited but overwhelmingly supported the regulation of kratom sale since there has been little study of this botanical, which has been used and abused as a substitute for opiates. No evidence-based clinical studies of its effectiveness as a therapy exist, and over-the-counter and internet availability are problematic.

- (5) RESOLUTION 512 - OPPOSITION TO USP 800

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 512 be adopted.

HOD ACTION: Resolution 512 adopted.

Resolution 512 asks that our American Medical Association work with stakeholders to advocate against policies mandating adherence to those elements of chapter 800 that have unproven and uncertain value.

Testimony explained that certain standards contained in Chapter <800> substantially affect how physician practices must manage the receipt, storage, dispensing, administration, and disposal of such products and expressed the view that USP did not adequately consult or collaborate with physician societies before finalizing the Chapter <800> standards. These standards will apply to all healthcare workers who perform these activities. USP Chapter <800> is considered an enforceable standard, meaning state boards of pharmacy and other regulatory entities can require regulated facilities to comply with its directives. Testimony noted that the AMA submitted comments as part of the public review process for the draft chapter. Your Reference Committee is aware that these comments were submitted in conjunction with several national pharmacy organizations and expressed "global concerns with

regulatory overlap, as well as the costs of facility compliance with <800> relative to any improvement to clinical safety that might result from its implementation.” Testimony further expressed the belief that the standards in <800> will impose overly burdensome new requirements on all health care entities that handle hazardous drugs, which would create financial and administrative burdens for physician practices, especially those practicing in an independent manner. Having to meet these new requirements could affect practice viability and the ability to provide patient care. For all of these reasons, your Reference Committee recommends adoption of this resolution.

(6) RESOLUTION 515 - NPS REPORT DISTRIBUTION TO PRACTICING PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 515 be adopted.

HOD ACTION: Resolution 515 adopted.

Resolution 515 asks that our American Medical Association distribute and promote the National Pain Strategy report to practicing physicians.

Testimony noted the overarching importance of the National Pain Strategy (NPS) as an important path forward to addressing the dual concerns of public health problems related to prescription opioid misuse, and creating a comprehensive population health-level strategy for pain prevention, treatment, management, and research. Consistent supportive testimony was offered for having the AMA assist in promoting the recommendations in the report to practicing physicians to help foster awareness of the approaches recommended by the NPS.

(7) RESOLUTION 518 - PROMOTION OF MILLILITER-ONLY FOR LIQUID MEDICATION DOSING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 518 be adopted.

HOD ACTION: Resolution 518 adopted as amended to read as follows:

RESOLVED, That our American Medical Association advocate to relevant federal and state entities for the exclusive use of metric-based dosing with milliliters (mL) and milligrams (mg) for orally administered liquid medications;

RESOLVED, That our AMA advocate that dispensing pharmacies be required to provide a device calibrated in milliliters for medication administration.

Resolution 518 asks that our American Medical Association (1) advocate to relevant federal and state entities for the exclusive use of metric-based dosing with milliliters (mL) for orally administered liquid medications; and (2) advocate that dispensing pharmacies be required to provide a device calibrated in milliliters for medication administration.

Limited but supportive testimony was offered for this resolution. Additionally, some testimony requested the inclusion of language for pharmacists to transpose prescription instructions from non-metric measurements to milliliters. Your Reference Committee believes the language in the Resolution as written covers the relevant issues.

(8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 - AN EXPANDED DEFINITION OF WOMEN'S HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Science and Public Health Report 5 be amended by addition to read as follows:

1. That our American Medical Association (AMA) recognize the term “women’s health” as inclusive of all health conditions for which there is evidence that women’s risks, presentations, and/or responses to treatments are different from those of men, and encourage that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Science and Public Health Report 5 be amended by addition to read as follows:

2. That Policy H-525.991, Inclusion of Women in Clinical Trials, be amended by addition to read as follows:

1. Our AMA encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; 2. supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and 3. encourages translation of important research results into practice.
(Modify Current HOD Policy)

RECOMMENDATION C:

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

HOD ACTION: Council on Science and Public Health Report 5 adopted as amended.

Council on Science and Public Health Report 5 briefly reviews the basis of sex differences in health and disease, selected disease areas in which sex differences are apparent, social and environmental factors that impact the health of men and women differently, and the role of women as clinical research participants. It recommends that (1) our American Medical Association recognize the term “women’s health” as inclusive of all health conditions for which there is evidence that women’s risks, presentations, and/or responses to treatments are different from those of men, and encourage that evidence-based information regarding the impact of sex and gender be incorporated into practice; (2) Policy H-525.991, Inclusion of Women in Clinical Trials, be amended by addition to read as follows: 1. Our AMA encourages the inclusion of women in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; 2. supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and 3. encourages translation of important research results into practice; and (3) Policy H-525.988, Sex and Gender Differences in Medical Research, be reaffirmed.

Testimony supported the Council’s report and recommendations, and several delegations thanked the Council for developing this report. An individual asked that a recommendation be added encouraging that evidence-based information on the impact of sex and gender be incorporated into medical practice, research, and training. Additionally, the American College of Obstetricians and Gynecologists asked that Recommendation 2 include the

concept that pregnant women be included in research where appropriate. The Council supported the suggested amendments. Your Reference Committee therefore recommends the recommendations be adopted as amended.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 9 -
INCREASING AWARENESS OF NOOTROPIC USE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 9 be amended by addition of a new recommendation:

5. That our AMA urge the Federal Trade Commission to examine advertisements for dietary supplements and herbal remedies that claim cognitive enhancement to ensure that they are truthful and not misleading, and are substantiated.(Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 9 adopted as amended.

Council on Science and Public Health Report 9 evaluates the use of nootropics (also called “smart drugs”) which are prescription drugs, supplements, or other substances that are claimed to improve cognitive functions of healthy individuals, particularly executive function, memory, learning, or intelligence. It recommends that our American Medical Association (1) (a) oppose the prescription of controlled substances, including stimulants and wakefulness-promoting agents, for the purpose of cognitive enhancement in otherwise normal, healthy individuals; and (b) discourage the nonmedical use of prescription drugs, including stimulants and wakefulness-promoting agents for cognitive enhancement at all levels of education and in the workplace; (2) encourage continued research into the risks and benefits of drugs and other substances for improving function in patients undergoing cognitive decline or who are experiencing cognitive impairment; (3) encourage more research into the patterns of use, as well as risks and benefits, of dietary supplements (including herbal remedies) being promoted for cognitive enhancement; and (4) rescind Policy D-100.969, “Increasing Awareness of Nootropic Use.”

Testimony was broadly supportive of the Council’s recommendations, including opposing physician prescribing of nootropic agents in otherwise healthy individuals, and the Council’s amendment to urge the Federal Trade Commission to examine the advertising practices of various companies and internet purveyors who are engaged in marketing various nootropic agents, either singly or in combination. Given the current trends in misuse of prescription stimulants, judicious prescribing is especially important for this class of drugs.

(10) RESOLUTION 505 - RADON TESTING IN RENTALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-455.986 be amended by addition and deletion to read as follows:

Radon in ~~Homes~~ Residential Dwellings and other Buildings

The AMA supports (1) assuming a leadership role in educating physicians, others of the health care community, and the public concerning the significance of radon levels in ~~homes~~ residential dwellings and other buildings and the possible health effects of those levels; and (2) encouraging the real estate

community to increase transparency and disclosure of prior radon testing, and the most recent results of such testing.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-455.986 be adopted in lieu of Resolution 505.

HOD ACTION: Amended Policy H-455.986 adopted in lieu of Resolution 505.

Resolution 505 asks that our American Medical Association support transparency and disclosure in prior radon testing, the most recent results of such testing, prior mitigation or remediation efforts, and other relevant information to protect renters and tenants when entering into a lease.

Testimony in support of the resolution relayed studies highlighting the harmful affects of radon, as well as awareness of state-level legislation proposing radon mitigation efforts. However, your Reference Committee believes that existing policy could be strengthened to address Resolution 505, and recommends adopting amended Policy H-455.986.

(11) RESOLUTION 506 - HEART DISEASE AND WOMEN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 506 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association and its partner organizations facilitate increased awareness of heart disease in women (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA support education on preventive measures for heart disease in women (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA encourage its members to foster increased comprehensive care of heart disease as it is the number one cause of death in women (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA promote research to address the gaps in knowledge related to coronary pathophysiology, optimal diagnostic testing and imaging, and optimal pharmacologic and interventional strategies (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA encourage additional research to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women. (Directive to Take Action)~~

RESOLVED, That our American Medical Association supports increased awareness and education on preventive measures for heart disease in women and encourages comprehensive care of heart disease in women; (New HOD Policy) and be it further

RESOLVED, That our AMA urges research to address the gaps in knowledge related to coronary pathophysiology and diagnostic, treatment, and interventional strategies for heart disease in women; and to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 506 be adopted as amended.

HOD ACTION: Resolution 506 adopted as amended.

Resolution 506 asks that (1) our American Medical Association (AMA) and its partner organizations facilitate increased awareness of heart disease in women; (2) our AMA support education on preventive measures for heart disease in women; (3) our AMA encourage its members to foster increased comprehensive care of heart disease as it is the number one cause of death in women; (4) our AMA promote research to address the gaps in knowledge related to coronary pathophysiology, optimal diagnostic testing and imaging, and optimal pharmacologic and interventional strategies; and (5) our AMA encourage additional research to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women.

Overwhelmingly supportive testimony favored the resolution, pointing out that heart disease is the number one killer of women, and education, awareness, and research are essential for appropriate prevention, detection, and treatment. Your Reference Committee agrees with this testimony, but believes that for the sake of clarity and simplicity, the resolution be amended to focus on the key points of education/awareness and research. It therefore recommends adoption of the resolution as amended.

(12) RESOLUTION 507 - INTERVENTIONS FOR OPIOID DEPENDENT PREGNANT WOMEN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends the following be adopted in lieu of Resolution 507:

HOD ACTION: Alternate Resolution 507 adopted in lieu of Resolution 507.

RESOLVED, that Policy H-420.969 Legal Interventions During Pregnancy be reaffirmed (Reaffirm HOD Policy); and be it further

RESOLVED, that Policy H-420.962 Perinatal Addiction-Issues in Care and Prevention be amended by addition and deletion to read as follows:

The AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant patients with substance abusers use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation ~~rehabilitative treatment appropriate to their specific physiological and psychological needs~~; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol ~~abuse~~ use during pregnancy and to routinely inquire about alcohol and drug use in the course of providing prenatal care. (Modify HOD Policy)

Resolution 507 asks that our American Medical Association (1) advocate for increased funding for programs for education, prevention and treatment of opioid use disorder in pregnant women; (2) advocate for comprehensive oversight of medication assisted treatment for pregnant women with opioid use disorder; and (3) oppose the fetal assault laws and instead lobby for increased funding for comprehensive programs to treat women with substance abuse problems.

Testimony noted the complexity of this issue; broad based support was expressed for the need to better address substance use in pregnant women and for the goals of this resolution. Testimony also noted that harm that can emanate from the existence of state laws that criminalize substance use in the context of pregnancy. Guidelines exist to help manage substance use, including opioids in pregnant women. Current AMA policy already opposes criminal sanctions of pregnant women for potentially harmful behaviors involving drugs and advocate for increased funding for treatment. It is essential to improving outcomes that treatment be accomplished by physician led teams, in a collaborative fashion and with provision of the necessary mentoring services. Your Reference Committee recommends reaffirming and amending current policy to accomplish these tasks.

Policy recommended for reaffirmation:

H-420.969, Legal Interventions During Pregnancy

Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women: (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision. (3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate. (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs. (6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation.

(13) RESOLUTION 511 - TRANSPARENCY IN TELEVISION ADVERTISING OF UNREGULATED MEDICATIONS AND MEDICAL DEVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-150.954 be amended by addition and deletion to read as follows:

H-150.954, Dietary Supplements and Herbal Remedies

(1) Our AMA will work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies. (2) Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA postmarketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement. (3) Our AMA

work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements. (4) Our AMA supports ~~t~~That the product labeling of dietary supplements and herbal remedies: (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: “This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease.” This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product; (b) should not contain prohibited disease claims. (5) Our AMA supports the FDA’s regulation and enforcement of labeling violations and FTC’s regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies. (6) ~~(5)~~ Our AMA urges tThat in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label. ~~(6)~~ (7) Our AMA continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-150.954 be adopted as amended in lieu of Resolution 511.

HOD ACTION: Policy H-150.954 adopted as amended in lieu of Resolution 511.

Resolution 511 asks that (1) our American Medical Association (AMA) adopt policy that all non-FDA-approved health care related products advertised on all media that are promoted with respect to health conditions display the following warning: “These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.” This warning must be prominently stated in print or voice throughout the advertisement for consideration by the consumer; and (2) it be AMA policy that all advertisements for health care related products not approved by the FDA include evidence-based information about the risks and benefits of the product.

Testimony noted support for Resolution 511 since, despite the efforts of physicians, consumers still encounter unregulated medications, supplements, and devices that are advertised on television and in print that can be misleading. However, not all proponents of the Resolution fully understood that the request was outside of the scope of the framework for both the FDA’s and FTC’s federal regulations regarding labeling and advertising for these products (and even some FDA approved products). The Council on Science and Public Health offered important clarifying statements regarding the types of statements that are permitted on dietary supplements and the roles of the FDA and FTC. In written testimony the FDA also commented that including evidence-based information about the risks and benefits of products could have the unintended consequence of making the advertisements seem more like prescription drug advertisements and could be misleading to consumers. Your Reference Committee offers the amendment of an existing policy to clarify the issues with federal regulations.

(14) RESOLUTION 513 - ACTION TO ADDRESS ILLEGAL METHAMPHETAMINE PRODUCTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 513 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association supports: (1) a national ban on over the counter sales of pseudoephedrine, ephedrine, phenylpropanolamine, and any other current or future products that are able to~~

~~be used to produce methamphetamine; and (2) the replacement of over-the-counter products containing pseudoephedrine, ephedrine, phenylpropanolamine, and other like products used to produce methamphetamine with their tamper- or meth-resistant counterparts (New HOD Policy); and be it further~~

~~RESOLVED, That our American Medical Association work with the pharmaceutical and retail industries to encourage the voluntary removal of or requirement for a prescription for non-tamper-resistant pseudoephedrine, ephedrine, phenylpropanolamine, and other like products from businesses that sell such products over the counter until such time as a ban on the sale of these products is implemented. (Directive to Take Action)~~

RESOLVED, That our American Medical Association supports: (1) the widespread and proper use of the National Precursor Log Exchange (NPLEx) for pseudoephedrine-containing OTC products; (2) the replacement of current pseudoephedrine-containing OTC products with formulations that are resistant to methamphetamine production; and (3) initiatives that focus on prevention and treatment of methamphetamine abuse. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 513 be adopted as amended.

HOD ACTION: Resolution 513 adopted as amended.

Resolution 513 asks that our American Medical Association (1) support 1. a national ban on over-the-counter sales of pseudoephedrine, ephedrine, phenylpropanolamine, and any other current or future products that are able to be used to produce methamphetamine, and 2. the replacement of over-the-counter products containing pseudoephedrine, ephedrine, phenylpropanolamine, and other like products used to produce methamphetamine with their tamper- or meth-resistant counterparts; and (2) work with the pharmaceutical and retail industries to encourage the voluntary removal of or requirement for a prescription for non-tamper-resistant pseudoephedrine, ephedrine, phenylpropanolamine, and other like products from businesses that sell such products over-the-counter until such time as a ban on the sale of these products is implemented.

Testimony noted the use of pseudoephedrine to manufacture clandestine methamphetamine and its availability OTC (behind the pharmacy counter). There was support for the use of tamper-resistant pseudoephedrine formulations that cannot be easily utilized in methamphetamine synthesis. There was some confusion about the meaning of the terminology “tamper resistant” and clarification that tamper resistant does not refer to packaging and is instead referring to the formulation of the drug and also that it does not mean “tamper proof.” Concern was raised regarding the increased burden on physicians when patients with colds/allergies seek prescriptions for pseudoephedrine should pseudoephedrine become a prescription drug. There was some opposition to the Resolution; the intent was appreciated, but opponents believe methamphetamine manufacturers will still find way to access the drug despite increased regulations. Better use of the National Precursor Log Exchange (NPLEx) was raised as possible solution. In written testimony, the FDA clarified that Nexafed and Zephrex-D are not FDA approved per se, but are marketed under the OTC Drug Review. The Council on Science and Public and Health offered clarifying comments regarding the availability of pseudoephedrine without a prescription, but noting that is available behind the pharmacy counter in all 50 states, and offered substitute language for the Resolution, with which your Reference Committee agrees.

(15) RESOLUTION 516 - EDUCATING CLINICIANS AND THE PUBLIC ABOUT AMEBIC MENINGOENCEPHALITIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 516 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association support CDC training and education efforts relating to Primary Amebic Meningoencephalitis (PAM) (New HOD Policy); and be it further

~~RESOLVED, That our AMA support required national reporting of PAM (New HOD Policy); and be it further~~

RESOLVED, That our AMA support clinical guidelines and standards of care that promote rapid diagnosis and effective treatment of PAM. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 516 be adopted as amended.

HOD ACTION: Resolution 516 adopted as amended.

Resolution 516 asks that our American Medical Association (1) support CDC training and education efforts 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.

Testimony noted the rapid and severe decline of those affected by primary amebic meningoencephalitis (PAM), which often mimics meningitis and is usually diagnosed post-mortem. Testimony supported education and awareness efforts and guidelines for physicians so that PAM can be more rapidly diagnosed, giving the patient a better chance at survival. The authors also proposed that PAM be added to the national notifiable disease list. The Council on Science and Public Health provided an explanation of the formal process that the CDC and the Council on State and Territorial uses to determine appropriateness of a disease being added to the nationally notifiable disease list, including whether and how easily it is spread from person to person. The Council also noted that the CDC tracks PAM through its Waterborne Disease and Outbreak Surveillance System (WDOSS). Your Reference Committee agrees with the importance of education, awareness, and guidelines for treatment, and recommends adoption of Resolves 1 and 3. However, given the questions of whether PAM would qualify for the nationally notifiable disease list and the fact that it is tracked by WDOSS, your Reference Committee recommends that Resolve 2 not be adopted.

(16) RESOLUTION 519 - SUPPORT FOR HEMORRHAGE CONTROL

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 519 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control (New HOD Policy); and be it further

RESOLVED, That our AMA encourage, through state medical and specialty societies, the inclusion provision of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders. law enforcement, fire, rescue and emergency medical personnel.(New HOD Policy); and be it further

~~RESOLVED, That our AMA advocate for the inclusion of hemorrhage control supplies (including pressure bandages, hemostatic dressings and tourniquets) on all commercial aircraft. (New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 519 be adopted as amended.

HOD ACTION: Resolution 519 adopted as amended.

Resolution 519 asks that our American Medical Association (1) encourage state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control; (2) encourage, through state medical and specialty societies, the provision of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for law enforcement, fire, rescue and emergency medical personnel; and (3) advocate for the inclusion of hemorrhage control supplies (including pressure bandages, hemostatic dressings and tourniquets) on all commercial aircraft.

Testimony was overwhelmingly supportive of this resolution, highlighting the importance of this issue. Your reference committee recommends an amendment in Resolve 2 to be inclusive of all first responders. In addition, the resolution sponsors asked that the third resolve be deleted because it detracts from the focus of the Resolution. Your Reference Committee concurs and recommends adoption as amended.

(17) RESOLUTION 521 – TRANSGENERATIONAL EFFECTS OF ENVIRONMENTAL TOXINS ON REPRODUCTIVE HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 521 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage study of the evidence on the possible transgenerational effects of environmental toxins on reproductive health and development, ~~with a report back at the 2016 Interim Meeting~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Resolution 521 be adopted as amended.

HOD ACTION: Resolution 521 adopted as amended.

Resolution 521 asks that our American Medical Association study the evidence on the possible transgenerational effects of environmental toxins on reproductive health and development, with a report back at the 2016 Interim Meeting.

Testimony supported the intent of this resolution, and noted the severe effects that environmental toxins can have on people several generations removed from exposure. An individual pointed out that the Veteran's Health Administration is currently conducting a study about environmental toxin exposure and the effects that it has on offspring of those exposed. The Council on Science and Public Health also supported the concept of such a study, but testified that the complexity of this topic made it unlikely that our AMA has the resources or expertise to carry out the request in the Resolution. Your Reference Committee agrees about the importance of the study, and therefore recommends an amendment to encourage the study, but not specifying that the AMA carry it out.

(18) RESOLUTION 514 - OPPOSING TAX DEDUCTIONS FOR DIRECT-TO-CONSUMER ADVERTISING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 514 be referred.

HOD ACTION: Resolution 514 referred.

Resolution 514 asks that our American Medical Association oppose allowing costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes.

While testimony in favor of the resolution highlighted that it would expand on current AMA policy supporting a ban on direct-to-consumer advertising, your Reference Committee believes that this issue is complex, and since it was noted that a Board report is in progress on DTC advertising, it recommends that the Board report also address the tax deduction issue. Your Reference Committee therefore recommends referral.

(19) RESOLUTION 520 – MEDICAL MARIJUANA USE IN WOMEN OF REPRODUCTIVE AGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 520 be referred for decision.

HOD ACTION: Resolution 520 referred for decision.

Resolution 520 asks that our American Medical Association (1) adopt the American College of Obstetrics and Gynecology Committee on Obstetric Practice’s policies on marijuana use during pregnancy and lactation, as follows: 1. Before and during pregnancy, all women should be asked about their use of tobacco, alcohol, other drugs (including marijuana), and medications used for nonmedical reasons. 2. Women reporting marijuana use should be counseled about concerns regarding potential adverse health consequences of use during pregnancy. 3. Women who are pregnant or contemplating pregnancy should be encouraged to avoid marijuana use. 4. Pregnant women or women contemplating pregnancy should be encouraged to avoid use of marijuana for medicinal purposes in favor of an alternative therapy for which there are better pregnancy-specific safety data. 5. There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged; (2) encourage continuing medical education for licensed physicians who certify patients to use medicinal marijuana, include training about the risks of marijuana on reproduction, pregnancy, and breastfeeding; (3) encourage physicians who certify patients to use medicinal marijuana counsel women and men of reproductive age on the risks that marijuana use has on reproduction, pregnancy, and breastfeeding; (4) encourage physicians who certify female patients to receive marijuana for medical use to assess their patients’ pregnancy status and contraceptive method at each visit; and (5) request and recommend that appropriate scientific agencies proceed with necessary research on the health effects of medicinal marijuana.

Limited but supportive testimony was offered for this resolution, and agreement was evident about the prevailing need for physicians to be vigilant about advising women of childbearing age or who are pregnant about the hazards of cannabis use and potential fetal exposure. Concerns were expressed about promulgating use of the term “medical marijuana” and of endorsing specific policy established by another medical specialty. Other conceptual problems with the resolution as written are the AMA’s general opposition to mandating content-specific CME, and the fact that our current policy discourages the establishment and operation of state-based programs that make cannabis available for medical use via physician recommendation. Nevertheless, this is an important topic given current patterns of cannabis use, and your Reference Committee recommends referral.

(20) RESOLUTION 501 - DISCLOSURE OF SCREENING TEST RISK AND BENEFITS PERFORMED WITHOUT A DOCTOR’S ORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 501 not be adopted.

HOD ACTION: Resolution 501 not adopted.

Resolution 501 asks that our American Medical Association (1) advocate that in the absence of an established physician-patient relationship and order for screening tests not rated “A” or “B,” the vendor of the wellness program should inform the patient of the USPSTF recommendation including that the evidence does not support the screening test; (2) advocate that if the test is not listed as an “A” or “B” by the USPSTF and the patient still would like the screening test, the wellness program vendor should offer the patient the opportunity to discuss the risks, benefits, and alternatives with a physician; (3) engage with federal regulators on whether for-profit vendors of health and wellness programs are in compliance with regulations applicable to marketing to consumers in view of the impact of such programs on patients; and (4) where possible, continue to work with state medical societies and state agencies to provide education.

Testimony from the resolution sponsors pointed out the proliferation of companies offering various health screening and wellness services that often are not supported by clinical guidelines and that occur without the input of a physician. Patients may unwittingly be harmed by undergoing certain screening tests, especially when the results are abnormal and set off a cascade of possibly unnecessary and costly follow-up tests. However, testimony overwhelmingly opposed the use of United States Preventive Services Task Force (USPSTF) “A” and “B” recommendations as the standards by which such wellness companies should operate. Although your Reference Committee concurs that the wellness programs should follow evidence-based medicine, the lack of clarity in the resolves, as well as the strong opposition to mention of the USPSTF, it believes that non-adoption is called for.

- (21) RESOLUTION 510 - REUNITING MILITARY SERVICE DOGS WITH SERVICE PERSONNEL HANDLERS AFTER RETIREMENT TO REDUCE PTSD

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 510 not be adopted.

HOD ACTION: Resolution 510 not adopted.

Resolution 510 asks that our American Medical Association work with appropriate federal and state organizations to support ways in which service animals can be reunited with their military handlers as a way to reduce the symptoms of and treat Post Traumatic Stress Disorder in our retired service men and women.

Testimony supported the use of therapy dogs in the treatment of post-traumatic stress disorder (PTSD), but noted the lack of evidence for this treatment. Some were confused as to whether the resolution was focused on reuniting military working dogs and their handlers versus veterans with PTSD whose symptoms could potentially be eased by therapy animals. Testimony also indicated that there are two separate laws with a mechanism in place that gives handlers the first right of adoption when military working dogs are returned to civilian society. Your Reference Committee applauds the military for creating these laws and believes this issue is addressed with these two laws. Given the paucity of data for treatment of PTSD with therapy dogs, your Reference Committee recommends that Resolution 510 not be adopted.

- (22) RESOLUTION 522 - GUIDELINES FOR PRESCRIBING OPIOID MEDICATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 522 not be adopted.

HOD ACTION: Resolution 522 adopted as amended to read as follows:

RESOLVED, That our American Medical Association work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities, in much the same way as is being done for hospice and palliative care, ~~because many vulnerable and frail elderly patients reside long-term in nursing facilities/skilled nursing facilities which are already under tremendous regulatory burden.~~

Resolution 522 asks that our American Medical Association work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications, in much the same way as is being done for hospice and palliative care, because many vulnerable and frail elderly patients reside long-term in nursing facilities/skilled nursing facilities which are already under tremendous regulatory burden.

In March 2016, the CDC released “Guidelines on the Use of Opioids for Chronic Pain.” This voluntary guidance was directed at primary care physicians and does not apply to the treatment of patients with cancer, or those who are undergoing palliative or end-of-life care. Conflicting testimony was offered on the relative value of opioid, and other medications for pain management in elderly patients, but support was expressed for the need to remove barriers to pain care, preserve clinician judgment, and have flexibility in place for developing optimal treatment plans. Despite a great deal of supportive testimony, the CDC Guidelines are voluntary and your Reference Committee believes that significant clinical distinctions exist between managing frail elderly patients in long term care facilities, and providing palliative and/or end-of-life care, and these should not be equated. The focus should be on the individual patient and the level of care that is needed. Furthermore, elderly patients also are susceptible to harms from opioid therapies that are not trivial. For these reasons, your Reference Committee believes that the policy advocated for in this resolution is not necessary and recommends that it not be adopted.

(23) RESOLUTION 502 - IN-FLIGHT MEDICAL EMERGENCIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-45.978, H-45.979, and H-45.981 be reaffirmed in lieu of Resolution 502.

HOD ACTION: Policies H-45.978, H-45.979, and H-45.981 reaffirmed in lieu of Resolution 502.

Resolution 502 asks that our American Medical Association (1) work with the Federal Aviation Administration (FAA) and other appropriate organizations to require airlines to provide a list of available in-flight medical supplies in accessible locations; (2) work with the FAA and other appropriate organizations to facilitate the creation of a centralized and standardized system to report all medical emergencies requiring assistance from a medically-trained passenger or from ground-based communications; and (3) work with the FAA and other appropriate organizations to ensure that a routine process exists to verify functionality of medical equipment and medicines used for in-flight medical emergencies.

Overall testimony acknowledged the importance of available resources for medical professionals to manage in-flight medical emergencies (IFMEs). However testimony was mixed regarding whether our AMA should adopt the proposed resolution or reaffirm current policies. Current regulatory standards are in place to equip in-flight medical kits, and to authenticate their readiness prior to flight, and substantial supportive AMA policy exists. Several personal anecdotes of accessing and using the on-board medical kits were described. Testimony from the Aerospace Medical Association supported reaffirmation of current policy. Policy H-45.981 addresses in-flight medical supplies, and Policy H-45.978 further urges that “decisions to expand the contents of in-flight medical kits be based on empirical data and medical consensus and tailored to the size and mission of the aircraft.” Policy H-45.979 encourages physicians to become “knowledgeable about medical resources and supplies available during an in-flight medical emergency.”

Policy H-45.978 already addresses reporting of medical emergencies, urging the FAA to “work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure ... efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form.” Further, Policy H-45.981 urges federal action to “require all U.S. air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies.” A current process is in place for capturing this data.

Policy H-45.978 addresses the concept of a routine process to verify medical resources and supplies, urging that the FAA work to ensure “adequate medical supplies and equipment aboard aircraft, and periodic assessment of system quality and effectiveness.” Accordingly, your Reference Committee recommends reaffirmation.

Policies recommended for reaffirmation:

H-45.978, In-flight Medical Emergencies

Our AMA urges: (1) that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure: (a) rapid 24-hour access to qualified emergency medical personnel on the ground; (b) at a minimum, voice communication with qualified ground-based emergency personnel; (c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies; (d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form; (e) adequate medical supplies and equipment aboard aircraft; (f) routine flight crew safety training; (g) periodic assessment of system quality and effectiveness; and (h) direct supervision by physicians with appropriate training in emergency and aerospace medicine.

H-45.979, Air Travel Safety

Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar.

H-45.982, Improvement in US Airlines Aircraft Emergency Kits

Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.

(24) RESOLUTION 504 - CONSERVATION, RECYCLING AND ENVIRONMENTAL STEWARDSHIP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-135.939 be reaffirmed in lieu of Resolution 504.

HOD ACTION: Policy H-135.939 reaffirmed in lieu of Resolution 504.

Resolution 504 asks that our American Medical Association (1) encourage all health systems to facilitate effective and robust recycling programs with a recommended goal of a 25% rate when feasible; (2) encourage all undergraduate and graduate medical education programs to facilitate effective and robust recycling programs when feasible; (3) encourage health systems, medical schools, and graduate medical education offices to evaluate their overall environmental impact, create goals for improvement and create a plan and a timeline to meet those goals; and (4) support resources and incentives that aid and encourage hospital employees and physicians who partake in environmentally conscientious activities (benefits for carpooling or taking the bus, showers at work for biking/jogging to work, etc.).

Limited but favorable testimony supported the use of robust recycling programs. Medical settings generate large amounts of waste that should be disposed of in a way that is environmentally-friendly. Others believed that while this issue is important, the AMA has a substantial amount of policy that already addresses these issues. Your Reference Committee also believes this issue is important, but notes that existing policy H-135.939 supports responsible waste management policies, including the promotion of appropriate recycling and waste reduction; building practices that help reduce resource utilization and contribute to a healthy environment; and community-wide adoption of ‘green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. It therefore recommends reaffirmation of H-135.939 in lieu of Resolution 504.

Policy recommended for reaffirmation:

H-135.939, Green Initiatives and the Health Care Community

Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of ‘green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

(25) RESOLUTION 517 - CARDIOPULMONARY RESUSCITATION (CPR) IN POST-ACUTE AND LONG-TERM CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-140.845 be reaffirmed in lieu of Resolution 517.

HOD ACTION: Policy H-140.845 reaffirmed in lieu of Resolution 517.

Resolution 517 asks that our American Medical Association further promulgate information to health care professionals and consumers to promote informed decision-making about Cardiopulmonary Resuscitation (CPR) by patients and their families.

Testimony relayed that CPR may not be appropriate for all patients, but there was extensive discussion on the importance of advance directives in long-term care. Your Reference Committee notes that section 2 of Policy H-140.845 addresses Resolution 517 by encouraging nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient’s advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility. Your Reference Committee believes that this policy addresses the discussion and concerns, and therefore recommends reaffirming Policy H-140.845.

Policy recommended for reaffirmation:

H-140.845, Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to

discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

REPORT OF REFERENCE COMMITTEE F

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2017 DUES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 4 adopted.

Board of Trustees Report 4 recommends no changes to our AMA membership dues levels for 2017. The Report further notes that our AMA last raised its dues in 1994.

Regular Members	\$420
Physicians in Their Second Year of Practice	\$315
Physicians in Military Service	\$280
Physicians in Their First Year of Practice	\$210
Semi-Retired Physicians	\$210
Fully Retired Physicians	\$84
Physicians in Residency Training	\$45
Medical Students	\$20

Your Reference Committee wishes to commend the Board of Trustees for their recommendation of continued stability in the cost of an AMA membership. Maintaining this dues level for more than 20 years is a reflection of the excellent stewardship of our trustees and staff.

(2) BOARD OF TRUSTEES REPORT 17 - PHYSICIAN ENTREPRENEUR ACADEMY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 17 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 17 adopted.

Board of Trustees Report 17 highlights our AMA's commitment to enhancing physicians' business and entrepreneurial education through the creation of a physician-entrepreneur speaker series, the development of an online platform to connect physicians with entrepreneurs, and sponsorship of MATTER, which gives physicians an opportunity to connect with entrepreneurs at the point of "idea conception" in order to develop new technologies, services, and products.

According to the report, our AMA has moved beyond studying the possibility of developing business and entrepreneurial education for physicians. Therefore, the Board of Trustees recommends that AMA Policy D-630.969, "Physician Entrepreneur Academy," be rescinded.

Your Reference Committee wishes to commend our Board of Trustees and staff for being at the forefront of identifying the business and entrepreneurial education needs of physicians. Continued emphasis in this area serves to highlight the value of AMA membership.

(3) BOARD OF TRUSTEES REPORT 18 - INCREASING COLLABORATION BETWEEN PHYSICIANS AND THE PUBLIC TO ADDRESS PROBLEMS IN HEALTH CARE DELIVERY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 18 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 18 adopted.

Board of Trustees Report 18 comes in response to AMA Policy H-160.904, “Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery.” The policy directs our AMA to consider the creation of a Citizens Advisory Group, consisting of patients, lay caregivers, and other non-physician members to assist with understanding the problems confounding the delivery of quality medical care, to educate the public on these matters, and to solicit public involvement in contacting elected officials to advocate for change.

In this report, the Board of Trustees concludes that the benefits of using digital engagement options, which provide sustainable mechanisms with regular feedback, prevail over the expense and logistical challenges of limited face-to-face conversations with the public. Therefore, the Board of Trustees recommends that AMA Policy H-160.904 be amended to read as follows:

Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care. (Modify Current HOD Policy)

Your Reference Committee notes that the 2015 Annual Report reflects that our AMA’s digital footprint recently has achieved some significant milestones, which include 1 million followers on social media through Facebook, Twitter, LinkedIn, and Google Plus, and 1.5 million views of *AMA Wire*[®]. Your Reference Committee agrees with the Board of Trustees recommendation.

(4) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Report of the House of Delegates Committee on Compensation of the Officers adopted.

The Report of the House of Delegates Committee on Compensation of the Officers recommends there be no changes to the Officers’ compensation for the period beginning July 1, 2016 through June 30, 2017.

Your Reference Committee received no testimony in response to the Report of the House of Delegates Committee on Compensation of the Officers and wishes to extend appreciation to the Committee for its continued oversight on behalf of our House of Delegates and to our officers for all that they do on behalf of our AMA.

(5) RESOLUTION 602 - PROTECTION OF PHYSICIANS’ PERSONAL INFORMATION

RECOMMENDATION:

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

HOD ACTION: Resolution 602 adopted.

Resolution 602 calls upon our AMA to work with the Federation of State Medical Boards to standardize the publicly available data on the State Medical Boards' websites to protect the personal data of physicians and to decrease the risk of identity theft.

Your Reference Committee received only supportive testimony favoring adoption of Resolution 602.

(6) RESOLUTION 605 - ETHNIC MEDICAL ASSOCIATION INVOLVEMENT
IN THE AMA

RECOMMENDATION:

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

HOD ACTION: Resolution 605 adopted.

Resolution 605 calls upon our AMA to work with ethnic medical associations to increase participation and involvement, and to identify their unique needs in order to engage them fully in our AMA.

Your Reference Committee received testimony supporting our AMA's diversity by working with ethnic medical associations to increase their involvement. Your Reference Committee recommends supporting the efforts of our International Medical Graduates Section (IMGS) by adopting this resolution.

(7) RESOLUTION 606 - AMENDING AMERICAN MEDICAL ASSOCIATION
MEETING POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 606 be adopted.

HOD ACTION: Resolution 606 adopted.

Resolution 606 calls upon our AMA to amend AMA Policy G-600.130, "Meeting Calendar and Locations" by deletion of the fourth item that states our AMA will reaffirm its well-established practice of returning to Hawaii every four to five years for the AMA House of Delegates Interim Meeting.

Your Reference Committee wishes to clarify that our AMA will host its 2017 and 2022 Interim Meetings in Hawaii. The resolution simply removes the directive that our AMA select a specific state on a regular basis.

Your Reference Committee believes that adoption of this resolution is the best way to remove the ongoing debate about Hawaii from our business discussions. Our AMA should be free at all times to consider all venues equally based on capacity, cost, location, availability, and other applicable considerations.

(8) RESOLUTION 607 – A GUIDE TO SELECTING A PHYSICIAN-LED
INTEGRATED SYSTEM

RECOMMENDATION:

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

HOD ACTION: Resolution 607 adopted.

Resolution 607 calls upon our AMA to collaborate with the Integrated Physician Practice Section and appropriate partners in the House of Delegates to develop within the next year a guide for physicians considering joining or

aligning with a physician-led integrated system, as well as information for physicians currently a part of or considering solo and small practices.

Your Reference Committee received limited testimony favoring adoption of Resolution 607. Your Reference Committee believes the requested guide would be a valuable resource to physicians considering alignment with a physician-led integrated system to determine if the system is compatible with their personal goals.

- (9) RESOLUTION 608 - INCLUDING MEDICAL STUDENTS IN STEPS FORWARD™ TO PREVENT BURN OUT AND PROMOTE STEPS FORWARD™ IN MEDICAL SCHOOLS NATIONWIDE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 608 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association modify the professional wellbeing modules of the STEPS Forward™ program to include medical students (Directive to Take Action); and be it further~~

~~RESOLVED, that our AMA promote the STEPS Forward™ program as a tool to implement strategies to prevent burnout in medical schools nationwide (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA encourage the Medical Student Section and the Academic Physicians Section medical students to promote the STEPS Forward™ program within medical schools. (Directive to Take Action)~~

RESOLVED, That our American Medical Association review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and that our AMA encourage the Medical Student Section (MSS) and Academic Physicians Section (APS) to promote these resources to medical students.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 608 be adopted as amended.

HOD ACTION: Resolution 608 adopted as amended.

Resolution 608 calls upon our AMA to modify the STEPS Forward™ program to create strategies for preventing medical student burnout and to promote the program in medical schools nationwide.

Your Reference Committee heard testimony strongly favoring the resolution, but also received testimony from the AMA Council on Medical Education (CME) and several others in favor of referral to allow our AMA to study and recommend options specifically for this population. Testimony for referral also reflected concern that adopting the resolution as written could be interpreted as a medical school curriculum mandate.

While your Reference Committee understands that the STEPS Forward™ program is intended for practicing physicians, the need to support medical student wellness is critical. Three of the modules in the STEPS Forward™ program specifically focused on preventing physician burnout are accessible to medical students. Your Reference Committee believes the professional wellbeing modules could include medical students.

At the same time, your Reference Committee agrees that there should be no perceived implication of a medical school curriculum mandate, which is the rationale for striking language from the resolution.

(10) RESOLUTION 601 - CHILDCARE AT THE AMA MEETINGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 601 be amended by addition and deletion to read as follows.

~~RESOLVED, That our American Medical Association survey recent attendees of the AMA Section meetings as well as the HOD on whether or not they have brought their children to AMA meetings and on the desire and need for onsite childcare and report back on these results at the 2016 Interim Meeting. (Directive to Take Action)~~

RESOLVED, That our American Medical Association review best practices and initiate a three-year pilot of onsite childcare at AMA Annual and Interim meetings of the House of Delegates and Sections beginning at the 2017 Annual Meeting with a report back regarding utilization and its impact on participation at AMA meetings. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 601 be adopted as amended.

HOD ACTION: Resolution 601 adopted as amended.

Resolution 601 calls upon our AMA to survey, with a report back at the 2016 Interim Meeting, recent attendees of our AMA Section and House of Delegates meetings asking whether they brought children to meetings and about the desire and need for onsite childcare.

Your Reference Committee believes that a survey of parents and guardians, regardless of the number surveyed, would reflect overwhelming interest in our AMA making onsite childcare services available for meeting attendees; therefore, your Reference Committee does not favor surveying meeting participants or AMA members at-large, as was suggested by the testimony.

Your Reference Committee's recommendation is based on testimony and a proposed amendment, and includes a shortened pilot period (three years) in order to provide a more timely evaluation. The amended wording also recommends that a pilot program would not begin until the 2017 Annual Meeting in order to allow our AMA more time to evaluate best practices and implement a workable pilot.

Your Reference Committee received testimony indicating that prior usage of onsite childcare was limited and significant costs were incurred by our AMA, which ultimately led to our AMA cancelling its childcare services contract with an external vendor. Counter testimony noted that our current AMA House of Delegates is more diverse and includes parents of young children who are often forced to temporarily suspend participating in AMA meetings because of childcare issues.

Lastly, your Reference Committee agrees with testimony that the cost of onsite childcare services shall be paid by those using the services.

(11) BOARD OF TRUSTEES REPORT 16 - CREATION OF THE AMA SUPER PAC

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 16 be referred.

HOD ACTION: Board of Trustees Report 16 referred.

Board of Trustees Report 16 is presented as follow-up to BOT Report 18-A-15 and in response to Resolution 606-I-14, which called upon our AMA to create, fund, and solicit contributions for an AMA super PAC to support or oppose candidates for federal office.

In this report, the Board of Trustees highlights the findings of a survey that was commissioned which indicates there is little to no interest by either AMA member or non-member physicians in contributing to or otherwise supporting an AMA-established super PAC. Therefore, the Board of Trustees recommends that the following be adopted in lieu of Resolution 606-I-14:

That AMA policy state that the use of AMA corporate funds, including reserves, is not a fiscally responsible option for funding a super PAC, especially given the 35 percent excise tax imposed on the use of such funds, and because of the lack of a reliable and sustainable outside funding source and the absence of interest among AMA member and non-member physicians, creation of a super PAC should not be pursued. (New HOD Policy)

Your Reference Committee heard testimony advocating for referral of the report for continued analysis and consideration of establishing an “AMA Fund for Physician Candidates (FPC).” The title change would eliminate the current negative connotation of the term “super PAC” and would narrow the fund’s focus to supporting only physician candidates for office.

Your Reference Committee notes that the testimony calling for another referral of this item is based on a deviation from the intent of Resolution 606-I-14. The Board of Trustees testified in favor of referral, and your Reference Committee supports this action.

(12) RESOLUTION 604 - LAYMEN’S MEDICAL ADVICE POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 604 not be adopted.

HOD ACTION: Resolution 604 not adopted.

Resolution 604 calls upon our AMA to support a public campaign to inform patients that when seeking medical advice, they are best served through partnership with their personal physician.

Your Reference Committee heard limited testimony in favor of adoption. Your Reference Committee supports the intent of the resolution; however, our AMA has no policy upon which to base a public campaign at this time.

Our AMA Council on Ethical and Judicial Affairs (CEJA) is currently drafting an ethical opinion for consideration at the 2016 Interim meeting that will provide guidance on the physician’s role as a patient educator. Your Reference Committee believes that the intent of Resolution 604 aligns with what CEJA will be addressing in their forthcoming report; consequently, your Reference Committee advises waiting for the ethical opinion.

(13) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

Board of Trustees Report 1 introduces our AMA's 2014 and 2015 Consolidated Financial Statements and an Independent Auditor's report, which are featured in a separate document titled, "2015 Annual Report" that was made available with the Handbook materials.

Your Reference Committee extends its appreciation to our Board of Trustees and staff for their continued efforts to maintain our AMA's solid financial position and membership success. The close of 2015 marked the 15th time in the last 16 years that our AMA reflected positive operating results, and it is the fifth consecutive year in which our AMA membership has grown. Your Reference Committee would be remiss if we were to not emphasize our AMA's leadership role this past year in achieving repeal of the sustainable growth rate (SGR) formula and for continued achievements among our AMA's three core focus areas of medical education, health outcomes, and practice sustainability and professional satisfaction.

REPORT OF REFERENCE COMMITTEE G

(1) BOARD OF TRUSTEES REPORT 20 - PRINCIPLES FOR MEASURING AND REWARDING PHYSICIAN PERFORMANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 20 adopted.

Board of Trustees Report 20 recommends that our AMA reaffirm Policies H-450.947, H-450.966, H-450.994 and H-450.999.

There was limited yet generally supportive testimony on this item. A speaker noted that it will be essential to review and evaluate the comprehensiveness of AMA policy addressing quality improvement moving forward. Your Reference Committee believes that the policies recommended for reaffirmation in Board of Trustees Report 20 appropriately address referred Resolution 716-A-15, as the existing AMA policy is substantially similar to the proposed principles for measuring and rewarding physician performance put forward in the referred resolution. Accordingly, your Reference Committee recommends that the recommendations of Board of Trustees Report 20 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 21 - DE-LINKAGE OF MEDICAL STAFF PRIVILEGES FROM HOSPITAL EMPLOYMENT CONTRACTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 21 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 21 adopted.

Board of Trustees Report 21 recommends that our AMA reaffirm Policy H-225.950, and develop resources to assist physicians transitioning from employment to independent practice.

Testimony on Board of Trustees Report 21 was supportive. A member of the Board of Trustees introduced the report and emphasized that AMA policy generally opposes linkage of medical staff membership and/or clinical privileges to an employment agreement. However, as noted in the report, there may be situations in which physicians could reasonably be expected to resign their medical staff membership or privileges upon termination of employment agreements, such as when the contract was for the provision of services on an exclusive basis or in cases of closed medical staffs. Additionally, it was noted that the AMA has developed a variety of resources to help physicians protect themselves from automatic rescission of medical staff membership and privileges, including a model employment agreement, model state legislation requiring hospitals to provide due process for employed physicians, and model medical staff bylaws intended to provide protection to employed physicians upon termination of their contracts.

Your Reference Committee is mindful that under Policy H-225.950, the AMA advocates that medical staff membership or privileges held during terms of employment should be rescinded only when called for by independent action of the medical staff and after the physician has been afforded full due process. Policy H-225.950 also encourages physicians to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions, and maintains that physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.

Testimony reiterated that it is not possible to de-link privileges from employment contracts in all situations, and also suggested that the aforementioned AMA resources be promoted among AMA members. Your Reference Committee points out that the issues addressed in the report are state issues and therefore would not be remedied by federal legislation as proposed by the sponsors of referred Resolution 820-I-15, who asked that an amended version of referred Resolution 820-I-15 be considered as an amendment to this report. Your Reference Committee believes that the Board report adequately and appropriately addresses de-linkage of medical staff privileges from hospital employment contracts. Accordingly, your Reference Committee recommends that the recommendations in Board of Trustees Report 21 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 7 - PRIOR
AUTHORIZATION SIMPLIFICATION AND STANDARDIZATION

RECOMMENDATION:

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

HOD ACTION: Council on Medical Service Report 7 adopted as amended.

7. That our AMA explore and report on potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures.

Council on Medical Service Report 7 recommends that our AMA reaffirm policies addressing the study of health plan prior authorization policies and advocacy regarding their implementation; address the negative impact of medication step therapy programs on patient access to needed treatment by supporting state legislation that places limitations and restrictions around the use of such programs and their interference with a physician's best clinical judgment; in collaboration with state medical associations and national medical specialty societies and relevant patient groups, create a set of best practices for PA and possible alternative approaches to utilization control; advocate that accreditation organizations include these concepts in their program criteria; and urge health plans to abide by these best practices in their PA programs and to pilot PA alternative programs.

Considerable supportive testimony was received on CMS Report 7, explaining that prior authorization is a significant source of frustration and administrative burden for physicians. Of particular note, significant testimony was supportive of recommendations 5 and 7, which call for the AMA to address the negative implications of step therapy protocols and the creation of a set of best practices for prior authorization and utilization management, respectively.

An amendment calling for the AMA to explore potential funding sources and mechanisms for payment of time spent completing prior authorization processes was received. Testimony from the Council on Medical Service on this amendment was persuasive, as it explained that the AMA currently has a CPT code for prior authorization payment in place, but health plans are not paying for this code. Additionally, the reference committee agreed with the report that AMA resources are better spent reducing the usage of prior authorization and its corresponding burdens.

Testimony was received that called for the reference committee to construct language to ensure that health plans would not negatively rate physicians based on their usage of services requiring prior authorization. Although your Reference Committee believes an exploration of this issue to be of potential value, the topic is not directly related to the issues presented in the report and may be better suited to a future resolution. For these reasons, your Reference Committee recommends that Council on Medical Service Report 7 be adopted.

(4) COUNCIL ON MEDICAL SERVICE REPORT 8 - BILLING OF "INCIDENT
TO" SERVICES

RECOMMENDATION:

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

HOD ACTION: Council on Medical Service Report 8 adopted.

Council on Medical Service Report 8 recommends that our AMA reaffirm Policy H-160.908.

Your Reference Committee heard limited yet supportive testimony on Council on Medical Service Report 8. Your Reference Committee believes that the policy recommended for reaffirmation in Council on Medical Service Report 8 underscores that “incident to” billing values physician leadership of the health care team and the supervision that physicians provide over the members of the team, with the ultimate responsibility of “incident to” services and the patient’s treatment generally resting with the physician. Accordingly, your Reference Committee recommends that the recommendation of Council on Medical Service Report 8 be adopted.

(5) RESOLUTION 713 - MEDICAL STAFF ENGAGEMENT AT CRITICAL ACCESS HOSPITALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 713 be adopted.

HOD ACTION: Resolution 713 adopted.

Resolution 713 asks that our AMA encourage all MD/DO(s) on staff at Critical Access Hospitals to contribute to the quality and safety of care provided in those organizations by participating in medical staff activities, including but not limited to credentialing and privileging activities.

Testimony on Resolution 713 was limited but supportive. The sponsor and another speaker testified to the importance of having physicians associated with smaller hospitals, such as Critical Access Hospitals, involved in medical staff activities. Your Reference Committee agrees and recommends that Resolution 713 be adopted.

(6) RESOLUTION 714 - MIXED MEDICAL STAFFS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 714 be adopted.

HOD ACTION: Resolution 714 adopted.

Resolution 714 asks that our AMA affirm its unyielding support for the principle that the members of the organized medical staff must work collectively to improve patient care and outcomes, regardless of the employment status or practice setting of each individual member; and through its Organized Medical Staff Section and other appropriate channels, provide guidance to medical staffs, including but not limited to effective medical staff leadership strategies and relevant updates to *the AMA Physician’s Guide to Medical Staff Organization Bylaws*, that facilitate representation of and encourage participation in medical staff activities by community-based and independent physicians.

Testimony on Resolution 714 was limited but supportive. The sponsor noted the importance of engaging both hospital-based and community physicians in medical staff activities so that all perspectives are represented and heard. Another speaker explained that Resolution 714 builds upon the AMA’s work with the American Hospital Association which led to the development of guiding principles on integrated leadership. Your Reference Committee supports the intent of Resolution 714 and recommends that it be adopted.

(7) RESOLUTION 715 - CMS EMERGENCY DEPARTMENT PATIENT EXPERIENCE OF CARE SURVEY (EDPEC)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 715 be adopted.

HOD ACTION: Resolution 715 adopted.

Resolution 715 asks that our AMA monitor the development of the Centers for Medicare and Medicaid Services' Emergency Department Patient Experience of Care (EDPEC) Survey and advocate for fair and reliable reporting that accurately reflects the quality of care provided by physicians and/or hospitals.

Your Reference Committee heard limited yet supportive testimony on this item. Your Reference Committee agrees with the intent of Resolution 715, and recommends that it be adopted.

(8) COUNCIL ON MEDICAL SERVICE REPORT 5 - VIRTUAL SUPERVISION OF "INCIDENT TO" SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 5 be amended by addition to read as follows:

1. That our American Medical Association (AMA) supports pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision if they are developed with specialty society input and abide by the following principles:

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 5 be amended by addition of a new Recommendation 1(j) to read as follows:

j) Patients receiving "incident to" services that are virtually supervised must have a choice of provider, as is required for all medical services.

RECOMMENDATION C:

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: Council on Medical Service Report 5 adopted as amended.

Council on Medical Service Report 5 recommends that our AMA support pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision, as long as the pilot programs abide by a set of outlined principles; and encourage national medical specialty societies to develop best practices and protocols for virtual supervision of "incident to" services, including specifying which services and procedures would not qualify for this practice.

There was generally supportive testimony on Council on Medical Service Report 5. An amendment was offered to ensure that pilot programs in Medicare testing virtual supervision of "incident to" services are developed with specialty society input. Your Reference Committee agrees that specialty societies have a central role to play in the

development of Medicare pilot programs enabling virtual supervision of “incident to” services and accepts the amendment offered. To spur such specialty society input, your Reference Committee appreciates that the second recommendation of the report encourages national specialty societies to develop best practices and protocols for virtual supervision of “incident to” services. An amendment was also offered to the recommendations of the report to ensure patients have the freedom to make an informed choice of provider when having the option to receive “incident to” services that would be virtually supervised. Your Reference Committee is recommending the addition of a new Recommendation 1(j), which states that patients receiving “incident to” services that are virtually supervised must have a choice of provider, as is required for all medical services, in order to address the intent of the amendment. A speaker also raised the issue of defining a frequency for physicians to visit the sites in person where patients receive procedures from non-physician practitioners or employees as outlined in Recommendation 1(g). However, your Reference Committee believes that the frequency of visits will need to vary based on the nature of the service or procedure performed. Your Reference Committee believes that the recommendations of this report provide a good framework to guide the development of pilot programs in Medicare that would test virtual supervision of “incident to” services. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

(9) COUNCIL ON MEDICAL SERVICE REPORT 6 - PHYSICIAN
COMMUNICATION AND CARE COORDINATION DURING PATIENT
HOSPITALIZATIONS

RECOMMENDATION A:

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

That our AMA modify Policy H-225.946 by addition and deletion to read as follows:

1. Our AMA ~~and the Organized Medical Staff Section (OMSS)~~ advocate that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; ~~with permission of the patient where the patient does not object,~~ prompt notification of such actively treating physician(s) ~~of the patient’s hospitalization and the reason for inpatient admission or observation status where such a relationship exists;~~ ~~exchange of contact information for routine and urgent situations or emergency department visits between the hospital-based and non-hospital-based treating physician(s);~~ to the extent possible, timely communication of the patient’s medical history and relevant clinical information by the patient’s primary care or specialty physician(s) to the hospital-based physician; notice to the patient that he/she may request admission and treatment by ~~such~~ actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges. 2. Our AMA ~~and the OMSS~~ advocate that a medical staff incorporate the above principles into medical staff bylaws, rules and regulations. 3. ~~Our AMA will 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.~~ (Modify HOD Policy)

RECOMMENDATION B:

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: Council on Medical Service Report 6 adopted as amended.

Council on Medical Service Report 6 recommends that our AMA reaffirm Policies D-160.945 and H-225.949; modify Policy H-225.946 to foster effective, bidirectional communications between hospital-based and community physicians regarding the care of hospitalized patients; and continue to advocate for third party payment for interprofessional consultative services related to the care of hospitalized patients.

Testimony on Council on Medical Service Report 6 was generally supportive. A member of the Council on Medical Service introduced the report and explained that the Council's recommendations expand and modify AMA policy on physician communication during the hospital admissions process that was adopted at the 2015 Interim Meeting. Some speakers testified that the report should focus more broadly on care coordination, or address communications during the discharge process. A member of the Council on Medical Service clarified that, as requested by referred Resolution 714-A-15, this report focuses predominantly on communications during the admissions process, and that a Council report on discharge communications will be presented to the House of Delegates at the 2016 Interim Meeting. Additional testimony pointed to existing AMA policy on care transitions.

Your Reference Committee agrees that this report addresses an important piece of care coordination and looks forward to the Council's forthcoming report on physician discharge communications. Your Reference Committee also concurs with testimony suggesting editorial changes to Recommendation 3 to promote communication regarding inpatient admissions as well as observation status cases, and also for emergency department visits. 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.

(10) COUNCIL ON MEDICAL SERVICE REPORT 10 - MEDICATION "BROWN BAGGING"

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 of Council on Medical Service Report 10 be amended by addition to read as follows:

4. That our AMA affirm that "brown bagged" pharmaceuticals be accepted for in-office or hospital administration only after the physician responsible for administering these medications determines that the individual patient, or his or her agent, is fully capable of safely handling and transporting the medication. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 10 adopted as amended.

Council on Medical Service Report 10 recommends that our AMA reaffirm Policies H-330.884 and D-330.960; affirm that decisions to accept or refuse "brown bagged" pharmaceuticals be made only by physicians responsible for administering these medications; affirm that "brown bagged" pharmaceuticals be accepted for in-office administration only after the physician responsible for administering these medications determines that the individual patient, or his or her agent, is fully capable of safely handling and transporting the medication; work with interested national medical specialty societies and state medical associations to oppose third party payer policies and legislative and regulatory actions that require patients to utilize "brown bagging" to ensure coverage of office-administered medications; and work with interested national medical specialty societies and state medical associations to oppose third party payer policies that reimburse office-administered drug costs at less than the provider's cost of acquiring the drug if the provider does not accept "brown bagging."

Testimony was generally supportive of Council on Medical Service Report 10. A member of the Council on Medical Service introduced the report, highlighted the Council's deliberations regarding the pros and cons of medication "brown bagging," and emphasized that physicians should have the right to decide whether to administer "brown bagged" pharmaceuticals. Additional testimony highlighted safety concerns related to "brown bagging" drugs, which are described in detail in the report.

A speaker testified that the report focused on "brown bagging" medications administered in physicians' offices but not in hospitals. A member of the Council clarified that "brown bagged" drugs that may be brought by patients to hospitals for administration are indeed addressed throughout the report. Your Reference Committee notes that "brown bagging" is repeatedly defined in the report as the practice of patients acquiring pharmaceuticals, such as chemotherapy drugs, through their pharmacy benefit and bringing the drugs to a physician's office or hospital to have them administered. For clarification purposes, your Reference Committee is supportive of an amendment to add "or hospital" to Recommendation 4. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted as amended and the remainder of the report be filed.

(11) RESOLUTION 701 - ONLINE ACCESS TO PRESCRIPTION DRUG FORMULARIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 701 be amended by addition to read as follows:

RESOLVED, That our American Medical Association promote the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 701 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support state medical societies in advocating for state legislation ~~of~~ to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans ~~in the state health exchanges~~.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 701 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA reaffirm Policy H-125.979, which states that our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. (Reaffirm HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 701 be adopted as amended.

HOD ACTION: Resolution 701 adopted as amended.

Resolution 701 asks that our AMA promote the value of online access to prescription drug formulary plans from all insurance providers nationwide, and support state medical societies in advocating for state legislation of online access to prescription drug formularies for all insurance plans in the state health exchanges.

There was generally supportive testimony on Resolution 701. Amendments were offered to both resolves to highlight the importance of and ensure access to up-to-date and accurate prescription drug formularies. An amendment was also offered to the second resolve of the resolution to make it applicable to all health plans. Speakers also noted that in order for formulary information to be available to physicians at the point of prescribing, that electronic health record systems must have the capacity to accept and display up-to-date formulary data. Your Reference Committee recommends that Policy H-125.979 should be reaffirmed to address that concern. Your Reference Committee agrees that prescription drug formulary transparency and accuracy are critical issues, and as such recommends that Resolution 701 be adopted as amended.

H-125.979, Private Health Insurance Formulary Transparency

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. 2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term. 3. Our AMA will develop model legislation 1) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, 2) requiring insurance carriers to make this information available to consumers by October 1 of each year and, 3) forbidding insurance carriers from making formulary deletions within the policy term. 4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours. 5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.

(12) RESOLUTION 702 - STUDY OF CURRENT TRENDS IN CLINICAL DOCUMENTATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 702 be amended by deletion of the first Resolve.

~~RESOLVED, That our American Medical Association study how modern clinical documentation requirements, methodologies, systems, and standards have affected the quality and content of clinical documentation~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 702 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA study the effectiveness of current graduate and undergraduate education training processes on~~ RESOLVED, That our AMA study the effectiveness of current graduate and undergraduate education training processes on ~~for~~ clinical documentation training for physicians as well as in graduate and undergraduate medical education.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

Resolution 702 asks that our AMA study how modern clinical documentation requirements, methodologies, systems, and standards have affected the quality and content of clinical documentation, and study current practices for clinical documentation training for physicians as well as in graduate and undergraduate medical education.

Testimony was supportive of Resolution 702, although some commenters believed existing policy and/or AMA activities already address some of its concerns. The Council on Medical Service explained that a review of clinical documentation was already underway in the forthcoming Dartmouth-Hitchcock study, which is outlined in CMS Report 7-A-16, and that the first resolved clause might prove to be duplicative once the results of that study are released. Your Reference Committee agrees with that testimony and believes that additional review of clinical documentation requirements would be premature at this time, thus recommending deletion of the first resolve.

The second resolve, which calls for a study on the education of physicians, graduate, and undergraduate medical students in current clinical documentation, received significant support, although testimony was limited to graduate and undergraduate medical student training. Particularly persuasive was testimony highlighting the unprepared state of many medical school graduates for effective clinical note-taking, which could result in inaccurate notes and potentially negative patient outcomes. As a result, your Reference Committee recommends amending the second resolve to ensure adequate focus of a study on undergraduate and graduate medical education. For these reasons, your Reference Committee recommends that Resolution 702 be adopted as amended.

(13) RESOLUTION 703 - VOLUNTARY REPORTING OF COMPLICATIONS FROM MEDICAL TOURISM**RECOMMENDATION A:**

Madam Speaker, your Reference Committee recommends Resolution 703 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support efforts that allow for the reporting and tracking of quality and safety issues associated with ~~ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from~~ medical procedures performed abroad. ~~(Directive to Take Action New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 703 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA reaffirm Policy H-450.937, which states that patients should only be referred for medical care outside the United States to institutions that have been accredited by recognized international accrediting bodies. (Reaffirm HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 703 be adopted as amended.

HOD ACTION: Resolution 703 adopted as amended.

Resolution 703 asks that our AMA ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from medical procedures performed abroad.

There was mixed testimony on Resolution 703. A member of the Council on Medical Service noted that individuals are able to report a quality or safety issue with a JCI-Accredited Organization to Joint Commission International.

The Council member also highlighted the importance of having the necessary inputs to know the incidence of quality and safety issues at institutions providing medical care abroad, which your Reference Committee recognizes as a notable concern. To account for existing initiatives that allow for the reporting, monitoring and tracking of issues and concerns associated with medical procedures performed abroad, your Reference Committee believes that Resolution 703 should be amended to allow for the AMA to be supportive of both new and existing initiatives that address quality and safety issues associated with medical care provided outside of the United States. Your Reference Committee is also recommending the reaffirmation of Policy H-450.937 to reiterate the importance of patients only being referred for medical care outside of the US to institutions that have been accredited by recognized international accrediting bodies. While this policy is essential to ensure patient safety and quality of care of medical care provided outside of the US, it also will make any effort to report, monitor and track quality and safety issues more meaningful and reliable. As such, your Reference Committee recommends that Resolution 703 be adopted as amended.

H-450.937, Medical Care Outside the United States

Our AMA advocates that employers, insurance companies, and other entities that facilitate or incentivize medical care outside the US adhere to the following principles: (1) Medical care outside of the US must be voluntary. (2) Financial incentives to travel outside the US for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. (3) Patients should only be referred for medical care to institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International or the International Society for Quality in Health Care). (4) Prior to travel, local follow-up care should be coordinated and financing should be arranged to ensure continuity of care when patients return from medical care outside the US. (5) Coverage for travel outside the US for medical care must include the costs of necessary follow-up care upon return to the US. (6) Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the US for medical care. (7) Access to physician licensing and outcome data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the US. (8) The transfer of patient medical records to and from facilities outside the US should be consistent with HIPAA guidelines. (9) Patients choosing to travel outside the US for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.

(14) RESOLUTION 704 - STEM CELL TOURISM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends Resolution 704 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA (1) encourage the study of appropriate guidance best practices for physicians to advise use when advising patients who seek seeking to engage in stem cell tourism and how to guide them in risk assessment; ~~and~~ (2) encourage further research on stem cell tourism; and (3) urge physicians to educate themselves on these issues. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 704 be adopted as amended.

HOD ACTION: Resolution 704 adopted as amended.

Resolution 704 asks that our AMA study best practices for physicians to advise patients seeking to engage in stem cell tourism and how to guide them in risk assessment, encourage further research on stem cell tourism, and urge physicians to educate themselves on these issues.

There was limited yet mixed testimony on this item. While recognizing that medical treatment involving stem cell therapies provided both in the US and abroad is in need of further research and study, your Reference Committee

believes that it may be premature to study best practices in this area, considering the state of the science. In addition, your Reference Committee notes that the AMA is not the appropriate organization to study elements beneficial for physicians to advise patients seeking to engage in stem cell tourism and how to guide them in risk assessment. Such a study should be carried out by physicians or physician organizations that have experience using stem cells for therapeutic purposes. Accordingly, your Reference Committee recommends that Resolution 704 be adopted as amended.

(15) RESOLUTION 707 - MEDICARE AND INSURANCE TAKEBACK PROCEDURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 707 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA advocate to ensure that the time frame for a public or private payer to audit a claim after payment of such claim be limited to the time period that a physician or hospital has to submit the claim to such public or private payer following the delivery of care. (New HOD Policy)~~

RESOLVED, That our AMA reaffirm Policy H-70.926, which provides that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less. (Reaffirm AMA Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 707 be adopted as amended.

HOD ACTION: Resolution 707 adopted as amended.

Resolution 707 asks that our AMA advocate to ensure that when a patient hospitalization is retrospectively found not to meet criteria for inpatient admission, then the take back amount be only the difference between the cost of the admission and the cost of necessary observation for that patient stay; advocate to ensure that, for any care provided to hospital patients who have Medicare, managed Medicare, or commercial insurance, hospitals have the option to rebill denied inpatient claims as outpatient claims, when a physician using clinical judgment makes a prospective decision to admit a patient who is later not found to meet admission criteria; and advocate to ensure that the time frame for a public or private payer to audit a claim after payment of such claim be limited to the time period that a physician or hospital has to submit the claim to such public or private payer following the delivery of care.

There was strong support for Resolution 707, which was described as offering fair solutions to the many problems for physicians related to retrospective reviews of hospital admissions. A member of the Council on Medical Service pointed out that Policy H-70.926, which stipulates that requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less, supersedes the third resolve clause of Resolution 707. Your Reference Committee concurs and recommends amending the third resolve to reaffirm Policy H-70.926, and adopting Resolution 707 as amended.

H-70.926, Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers
Our AMA policy is that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less.

(16) RESOLUTION 708 - CLINICAL PATHWAYS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 708 be amended by deletion of the second Resolve.

~~RESOLVED, That our AMA study (a) the criteria and processes which various payers require physicians to follow in using clinical pathways; (b) the administrative and financial impact to physicians resulting from the use of clinical pathways ; (c) the implications of such criteria and processes for patient access to care; and (d) whether information is publicly available to identify differences among pathways and to assess the potential for stakeholders to collaborate in the future in resolving or minimizing any such differences. The results of this study will be reported back to the HOD and to our AMA membership at large at the 2017 Annual Meeting (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 708 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA advocate that any effort to encourage, require or incentivize 100 percent concordance with a clinical pathways is unreasonable, undesirable, and potentially unsafe for patients (New HOD Policy); and be it further~~

RESOLVED, That our AMA reaffirm Policy H-320.949, which establishes that clinical practice guidelines, when used by health plans, must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care (Reaffirm HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 708 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA advocate that the names, professional affiliations, and potential conflicts of interest be made publicly available for all individuals and entities contributing to or influencing the development or revision of each clinical pathway, including research, analysis, assessment, and approval. (New HOD Policy)~~

RESOLVED, That our AMA reaffirm Policy H-410.953, which requires formal procedures to be adopted to minimize the potential for undue financial or other interests from influencing the development of clinical guidelines. (Reaffirm HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 708 be adopted as amended.

HOD ACTION: Resolution 708 adopted as amended.

Resolution 708 asks that our AMA support the development of transparent, collaboratively constructed clinical pathways that: (a) are implemented in ways that promote administrative efficiencies for both providers and payers; (b) promote access to evidence-based care for patients; (c) recognize medical variability among patients and individual patient autonomy; (d) promote access to clinical trials; and (e) are continuously updated to reflect the rapid development of new scientific knowledge. Also, Resolution 708 asks that our AMA study (a) the criteria and

processes which various payers require physicians to follow in using clinical pathways; (b) the administrative and financial impact to physicians resulting from the use of clinical pathways; (c) the implications of such criteria and processes for patient access to care; and (d) whether information is publicly available to identify differences among pathways and to assess the potential for stakeholders to collaborate in the future in resolving or minimizing any such differences. Finally, Resolution 708 asks that our AMA advocate that any effort to encourage, require or incentivize 100 percent concordance with a clinical pathways is unreasonable, undesirable, and potentially unsafe for patients; and advocate that the names, professional affiliations, and potential conflicts of interest be made publicly available for all individuals and entities contributing to or influencing the development or revision of each clinical pathway, including research, analysis, assessment, and approval.

Resolution 708 received supportive testimony during the hearing. Clinical pathways can provide useful guidance for clinicians in providing appropriate patient care. Physicians routinely are required to meet medical necessity requirements instituted by various health plans that lack transparency or consistency. Such requirements present a burden to physicians, who must keep track of a particular insurer's requirements and ensure that their clinical processes adhere to such restrictions in order for their patients to receive the appropriate coverage. Moreover, enabling each health plan to develop their own determination of what is clinically appropriate may cause a necessary course of treatment to vary from what is deemed medically appropriate by medical specialties and experts in the field. These concerns are aptly addressed in the first resolve of Resolution 708.

Council on Medical Service Report 7 recommends that the AMA convene a 2016 prior authorization workgroup that will evaluate alternatives to current prior authorization, including the usage of appropriate clinical guidelines, and make best practice recommendations, which will subsequently be advocated to be used by health plans. These impending actions will effectively accomplish the goals of the second resolve of resolution 708.

The third resolve of Resolution 708 establishes that any requirement that a clinical pathway be adhered to 100 percent of the time be deemed unreasonable and potentially harmful for physicians. These sentiments are expressed in AMA Policy H- 320.949, which establishes that clinical practice guidelines, when used by health plans, "must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care. The guidelines should also include a statement of their limitation and restrictions."

Similarly, the fourth resolve of Resolution 708 calls for the public disclosure of the names, professional affiliations, and conflicts of interest of all individuals involved in the development of clinical pathways. This important effort is currently codified in AMA Policy H-410.953, which requires formal procedures to be adopted to minimize the potential for undue financial or other interests from influencing the development of clinical guidelines, including, "required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants" and a requirement that "disclosures of panel members' conflicts of interest relating to specific recommendations be published with the guidelines or otherwise made public." Accordingly, although the intentions of the third and fourth resolve clauses are important, they are already sufficiently covered by current AMA Policy. Your Reference Committee recommends that Resolution 708 be adopted as amended.

H-320.949, Clinical Practice Guidelines and Clinical Quality Improvement Activities

Our AMA adopts the following principles for the development and application of utilization management guidelines: (1) The criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate. (2) These utilization management guidelines and the criteria for their application shall be developed with the participation of practicing physicians.(3) Appropriate data, clinical evidence, and review criteria shall be available on request.(4) When used by health plans or health care organizations, such criteria must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care. The guidelines should also include a statement of their limitations and restrictions.(5) Patients and physicians shall be able to appeal decisions based on the application of utilization management guidelines. (6) The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured. (7) Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician.

H-410.953, Ethical Considerations in the Development of Clinical Practice Guidelines

Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Clinical practice guidelines help inform physician judgment and decision making by physicians and patients. Clinical practice guidelines also have significant potential to meaningfully inform efforts to provide care of consistently high quality for all patients and to help shape development of sound public policy in health care. To achieve those ends, clinical practice guidelines must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that published guidelines are the ethically and scientifically credible product of development processes that are rigorous, independent, transparent, and accountable. To that end, the development or updating of clinical practice guidelines should meet the following expectations: 1. Guidelines/updates are developed independent of direct financial support from entities that have an interest in the recommendations to be developed. 2. Formal, scientifically rigorous methods and explicit standards are adopted for the review and weighting of evidence, the integration of expert judgment, and the strength of clinical recommendations. 3. Guideline panels have access to appropriate expertise among members or consultants, including not only relevantly qualified clinical experts but also appropriately qualified methodologists, representatives of key stakeholders, and, ideally, one or more individuals skilled in facilitating groups. 4. Ideally, all individuals associated with guideline development will be free of conflicts of interest during the development process and will remain so for a defined period following the publication of the guideline. 5. Formal procedures are adopted to minimize the potential for financial or other interests to influence the process at all key steps (selection of topic, review of evidence, panel deliberations, development and approval of specific recommendations, and dissemination of final product). These should include: a) required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants; b) clearly defined criteria for identifying and assessing the seriousness of conflicts of interest; and c) clearly defined strategies for eliminating or mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when participation by an individual with a conflicting interest cannot be avoided. 6. Guidelines are subject to rigorous, independent peer review. 7. Clear statements of methodology, conflict of interest policy and procedures, and disclosures of panel members' conflicts of interest relating to specific recommendations are published with any guideline or otherwise made public. 8. Guidelines are in the first instance disseminated independent of support from or participation by individuals or entities that have a direct interest in the recommendations.

(17) RESOLUTION 711 - ACCURATE MENTAL STATUS REPORTING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 711 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association define the core set of mental status information to be transmitted to be:~~

- ~~—Mental status abnormality present or absent;~~
- ~~—Features of cognition, including normal or abnormal alertness, orientation, attention, and/or thinking (psychosis);~~
- ~~—Etiology of a mental status abnormality or change, if present;~~
- ~~—Time course of a mental status abnormality or change, if present, including recency, expected duration, and permanence. (New HOD Policy)~~

RESOLVED, That our American Medical Association encourage interested national medical specialty societies to develop recommendations regarding mental status information that should be transmitted when patients transition care settings. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 711 be adopted as amended.

HOD ACTION: Resolution 711 adopted as amended.

Resolution 711 asks that our AMA define the core set of mental status information to be transmitted to be: mental status abnormality present or absent; features of cognition, including normal or abnormal alertness, orientation, attention, and/or thinking (psychosis); etiology of a mental status abnormality or change, if present; and time course of a mental status abnormality or change, if present, including recency, expected duration, and permanence.

Testimony on Resolution 711 was mixed. The importance of transmitting changes in patient mental status during care transitions was highlighted, particularly given the aging population and the increased potential for delirium among patients being moved from one care setting to another. Other speakers spoke in opposition to Resolution 711, which was perceived by some as overly prescriptive. It was also noted that the AMA is not the appropriate party to develop the core set of mental status information to be transmitted. Your Reference Committee agrees, and suggests amending Resolution 711 to encourage interested national medical specialty societies to develop recommendations regarding mental status information that should be transmitted when patients transition care settings.

(18) RESOLUTION 716 - MITIGATING ABUSIVE PRE-CERTIFICATION/PRE-AUTHORIZATION PRACTICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 716 be amended by addition to read as follows:

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education to encourage residency programs to offer administrative resources to housestaff for practice-based support, including but not limited to pre-certification and pre-authorization of medications and services.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 716 be adopted as amended.

HOD ACTION: Resolution 716 adopted as amended.

Resolution 716 asks that our AMA encourage residency programs to offer administrative resources to housestaff for practice-based support including but not limited to pre-certification and pre-authorization of medications and services.

Testimony was supportive of Resolution 716, which seeks to reduce the amount of administrative tasks that residents must complete during training, which detract from their clinical training and time devoted to patients. As highlighted in CMS Report 7-A-16, administrative tasks can require significant time, completion of which detracts from a clinician's time to provide patient care. Your Reference Committee found the Organized Medical Staff Section amendment calling for the AMA to work with the Accreditation Council for Graduate Medical Education (ACGME) on any recommendations to residency programs to be persuasive, since ACGME is responsible for residency program oversight. As a result, your Reference Committee recommends that Resolution 716 be adopted as amended.

(19) RESOLUTION 705 - RETAIL HEALTH CLINICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 705 be referred.

HOD ACTION: Resolution 705 referred.

Resolution 705 asks that our AMA encourage the study of patient care delivery within retail health clinics to ensure patient safety; encourage the study of, and pursue legislation to ensure the appropriate oversight of retail health clinics as an entity separate from an independent physician's practice and other health care facilities; and encourage the study of potential conflicts of interest where retail clinics are located within a store that includes a pharmacy as such co-locations could result in incentives to provide costly, unnecessary, inappropriate and uncoordinated health related services.

Your Reference Committee heard supportive testimony on Resolution 705. A member of the Council on Medical Service welcomed the study requested in Resolution 705, and suggested referral, for which there was support. Recognizing that the last study conducted by the Council on Medical Service on store-based health clinics was in 2007, your Reference Committee believes that an updated study on this issue would be appropriate as the retail clinic marketplace has evolved since then. Accordingly, your Reference Committee recommends that Resolution 705 be referred.

- (20) RESOLUTION 710 - ELIMINATE THE REQUIREMENT OF "H&P UPDATE"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 710 be referred.

HOD ACTION: Resolution 710 referred.

Resolution 710 asks that our AMA work to change Centers for Medicare & Medicaid Services' Medicare requirements for the "H&P Update" by modifying policy 482.24 (c)(4)(i)(B) and 482.51 (b)(1)(ii).

Testimony on Resolution 710 was mixed. The sponsoring delegation testified that physicians should not have to document "no change" in the patient's history and physical (H&P) update on the day of a procedure or surgery. Other testimony emphasized the importance of documenting updates on the date of surgery and potential risks associated with not documenting changes or "no change" in the patient's condition. One speaker noted that "H&P update" requirements are not particularly burdensome to physicians. Additional speakers noted the complexity of the issues brought up by Resolution 710, and that patient needs may differ depending on their health and the procedures they are receiving. Your Reference Committee concurs that the "H&P update" requirement deserves further study, and therefore recommends that Resolution 710 be referred.

- (21) RESOLUTION 712 - REMOVE PRICING BARRIERS TO TREATMENT OF HEPATITIS C (HCV)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 712 be referred.

HOD ACTION: Resolution 712 referred.

Resolution 712 asks that our AMA advocate with Congress and federal agencies for any necessary combination of legislation, regulation, negotiation with the pharmaceutical industry, and federal subsidies to lower the cost of treatment for all Americans infected with Hepatitis C virus using highly effective oral medications, to a price level that would make treatment affordable and accessible.

There was mixed testimony on Resolution 712. While speakers noted that the pricing of direct-acting antivirals for Hepatitis C remains a critical issue, others noted that drugs and biologics to treat other conditions also have very high prices. A member of the Council on Medical Service noted that the Council is developing a report on prescription drug pricing for the 2016 Interim Meeting. The Council member accordingly suggested referral of

Resolution 712, which received substantial support from other speakers. Speakers noted that the AMA should not take a disease-by-disease approach to drug pricing. Your Reference Committee agrees, and believes that mechanisms to reduce the cost of treatment of Hepatitis C should be considered alongside mechanisms to reduce the cost of prescription drugs and biologics more broadly, and as such recommends referral of Resolution 712.

(22) RESOLUTION 717 - UNFORESEEN CONSEQUENCES OF CORE MEASURES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 717 be referred.

HOD ACTION: Resolution 717 referred.

Resolution 717 asks that our AMA call for the immediate suspension of the SEP-1 core measure and any financial incentives or penalties relating to compliance with it; strongly discourage the implementation of further protocols, core measures, or directives concerning the care of patients in the outpatient or inpatient setting without structured trials designed to identify unforeseen costs and potential patient harms; strongly discourage the implementation of indiscriminant and not medically indicated screening or testing for “pre-existing” infection in patients in order to avoid financial penalties; and support any physician who refuses to perform testing or treatment that they feel is not medically indicated or potentially harmful to patients.

Your Reference Committee heard limited yet generally supportive testimony on Resolution 717. Speakers raised issues associated with compliance with the SEP-1 core measure. A member of the Board of Trustees noted that The Joint Commission has found itself in disagreement with CMS on this core measure. While recognizing that compliance with the SEP-1 core measure is a concern, your Reference Committee believes that the resolves of the resolution could have unintended consequences and be quite constraining to AMA advocacy if applied more broadly. Your Reference Committee also believes that an in-depth study of this issue could better inform and appropriately direct future AMA advocacy efforts. As such, your Reference Committee recommends that Resolution 717 be referred.