Southeast Resolutions – 2014 AMA Interim Meeting

*Please click on the underlined resolution number to see the full resolution.

Reference Committee B

Resolution # 210 – AMA Promotion of Improved Electronic Health Records – Florida

Resolution # 211 – CPR Training – Florida

Resolution # 214 – Pain Medicine – South Carolina

Resolution # 215 – Preauthorization – Florida

Resolution # 223 – Preservation of Small Medical Practices – Georgia

Resolution # 224 – Transparency and Labeling of Generic Medications – Georgia

Reference Committee F

Resolution # 604 – AMA-Provided Innovation Grants to Support New Physician Models to Improve Quality, Efficiency and Reduce Cost – Maryland

Resolution # 605 – Helping to Better Inform Legislators on Medical Matters – Maryland

Resolution # 606 – Creation of AMA Super PAC – Georgia

Rules for Campaign Parties

Reference Committee J

Resolution # 815 – Board Recertification to Maintain Hospital Staff Privileges – Alabama

Resolution # 817 – Medicare Coverage of Hearing Aids – Florida

Resolution # 820 – Antitrust Activity – Florida

Resolution # 821 – Review of Straddle Drug Pricing Rules for Medicare Part D Participants – New Jersey

Reference Committee K

Resolution # 920 – Combating the Medical Certification and its Attempt to Capture Into Unproven Certification Programs with its Regulations – Florida

Resolution # 921 – A Tobacco Free Military – New Jersey

Resolution # 922 – Child Safety Seats – Public Education and Awareness – Maryland

Resolution # 923 – Transparency of Pharmaceutical Manufacture – Maryland
Resolution # 928 - Cancellation of Maintenance of Certification – Georgia

Regulation of Electronic Nicotine Delivery Devices – Virginia

Private Payer Funding of Graduate Medical Education – Virginia

Opposition of Maintenance of Certification as Condition for Licensure, Credentialing, or Reimbursement – Virginia

Extension of Deadline to File Claim for CICA Tax Refund – Virginia

Physician Credit Card Payments by Health Insurance Companies – Virginia
Whereas, There remains a significant lack of interoperability between the current multitude of available Electronic Health Records (EHR) in America; and

Whereas, Every new requirement by the Centers for Medicare & Medicaid Services (CMS) results in a costly upgrade for physicians and health care facilities; and

Whereas, Every change in vendors is made more costly as the vendors require the physician and/or health care facility to purchase the patient data that is to be moved to the new EHR; and

Whereas, The current poor EHR design has been shown to interfere with the face-to-face interaction between the patient and physician; and

Whereas, The meaningful use program requires physicians and health care facilities to use certified EHR technology but many of these products have performed poorly in the practice setting; therefore be it

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

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

Fiscal Note: Minimal - less than $1,000.

Received: 9/26/14
Whereas, CPR training has been simplified and perfected over the last several years; and

Whereas, The first few minutes after a cardiac arrest are critical to maintaining normal cerebral function; and

Whereas, Other states are requiring high school students to be trained in CPR; therefore be it

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

Fiscal Note: Minimal - less than $1,000.

Received: 9/26/14

RELEVANT AMA POLICY

H-130.938 Cardiopulmonary Resuscitation (CPR) and Defibrillators
Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators; (5) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (6) endorses federal regulation and/or legislation increasing funding for cardiopulmonary resuscitation and defibrillation training of community organization personnel; and (7) supports the development and use of universal connectivity for all defibrillators. (CCB/CLRPD Rep. 3, A-14)

D-470.992 Implementation of Automated External Defibrillators in High-School and College Sports Programs
Our AMA supports state legislation and/or state educational policies encouraging: (1) each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator and trained personnel on its premises; and (2) athletic coaches, sports medicine personnel, and student athletes to be trained and certified in cardiovascular-pulmonary resuscitation (CPR), automated external defibrillators (AED), basic life support, and recognizing the signs of sudden cardiac arrest. (Res. 421, A-08)
Whereas, The Centers for Disease Control and Prevention (CDC) in 2013 declared prescription drug abuse an epidemic in the USA; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) felt pain was understated in US patients; and

Whereas, As in 2009 there were 4.6 million drug-related emergency department visits and one-half were related to prescription drugs; and

Whereas, 99% of Vicodin produced in the world is consumed in the United States; and

Whereas, One in 12 high school seniors reported non-medical use of Vicodin; and

Whereas, Prescription opioids have quadrupled since 1999; and

Whereas, Unintentional drug overdose deaths have increased to more than 12,000 a year from 1999 to 2008; and

Whereas, Prescription drug abuse is now one of the most disturbing drug problems; and

Whereas, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and soon CAHPS Clinician and Group Surveys (CG-CAHPS) scores over emphasize pain control, and remove the ability of physicians to appropriately prescribe drugs and treat pain based on sound physician judgment; therefore be it

RESOLVED, That our American Medical Association work to remove the pain survey questions from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and work to prevent the Centers for Medicare & Medicaid Services (CMS) from using pain scores as part of CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys (Directive to Take Action); and be it further

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

RESOLVED, That a patient and physician education program for non-narcotic pain control directed at the risk of addiction, diversion and abuse from prescription narcotics be promoted by our AMA (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate that commercial insurance and CMS payment for non-pharmaceutical treatments should be increased and also advocate for payment for team-based care of the pain patient (Directive to Take Action); and be it further

RESOLVED, That our AMA should encourage CMS to work with the states to develop non-punitive drug monitoring programs for physicians and patients to help reduce the use of prescription pain drugs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 09/30/14
Whereas, Managed Care employs preauthorization as a means of reducing utilization of resources and reducing cost of care for their group of insured individuals; and

Whereas, Some Managed Care organizations require physicians to obtain a pre-authorization for the following labs:

- Any thyroid panel (T3, T4)
- HIV
- Hepatitis C
- Hepatitis B
- ANA
- Clostridium difficile toxin
- Factor V Leiden
- H Pylori
- Strep Culture or DNA
- Any syphilis test
- Vitamin D level (at least 40% of people Vitamin D deficient, and in Hispanics it is closer to 70%)
- Drug screening
- Protein electrophoresis (or IFE)
- Any routine genital culture; and

Whereas, The AMA is on record as supporting the triple aim of improved access, better quality, and lower cost; and

Whereas, A delay in access to a needed service by an inappropriate preauthorization requirement may lead to decreased access, delayed and therefore lower quality care and higher cost; and

Whereas, Managed Care has extended the preauthorization process to prescription services, laboratory testing, imaging, and to most procedures to the point that there is clear interference with the sound practice of medicine and the patient-physician relationship; and

Whereas, AMA Policy H-320.950 (Eliminating Precertification) which was originally approved in 1999 and reaffirmed as recently as 2010, states that our AMA will advocate that all utilization review efforts focus on statistical outliers and advocate that managed care plans restrict their preauthorization requests to physicians whose claims have shown to be statistical outliers; therefore be it
RESOLVED, That our American Medical Association convene a task force to study the effects of current preauthorization practices by managed care organizations on the reasonable access to care by patients as well as evaluating the effects of preauthorization on physicians practices and consider possible actions by the AMA and/or other members of the Federation to address the undesirable impact of intrusive preauthorization policies by MCOs (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation to limit the use of preauthorization by managed care in a way that promotes the safe, sound practice of medicine while promoting the goals of the Triple Aim (Direction to Take Action); and be it further

RESOLVED, That our AMA work toward the creation and adoption of legislation that would limit the use of preauthorization by Medicare and Medicaid to those physicians who have been shown to be statistical outliers. (Direction To Take Action)

Fiscal Note: Estimated cost of $25,000 to implement resolution.

Received: 10/07/14

RELEVANT AMA POLICY

H-320.950 Eliminating Precertification
Our AMA will: (1) advocate that all utilization review efforts focus on statistical outliers, rather than routine blanket review of whole populations of physicians or all instances of particular services; (2) advocate that managed care plans restrict their preauthorization requests to physicians whose claims have shown to be statistical outliers; and (3) encourage CMS to adopt regulations prohibiting Medicare secondary insurance carriers from utilizing independent precertification criteria. (Res. 705, A-99; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation I-10)
Whereas, The Patient Protection and Affordable Care Act (PPACA) creates increased regulations on the practice of medicine in the United States; and

Whereas, The increase in cost of dealing with insurance companies and their adverse impact on patient care, including prior approval restrictions, payment denials, peer-to-peer interaction, specialty tiers which has been shown in 2005 to cost the average physician practice $82,000 to 85,000 a year per physician; and

Whereas, These practice expenses are increasing and physician payment has been decreasing leading physicians to be extorted to join larger groups; and

Whereas, Many physicians in private practices are deciding to go out of practice or join the larger entities because of these costs; and

Whereas, Some physicians joining hospital groups have been disenchanted with large groups and wish to return to private practice but are unable to do so within the same area due to non-compete clauses; and

Whereas, The state of Georgia has been losing physicians thus creating a physician shortage and this loss of practices has been leading to less physician availability in rural Georgia and urban Georgia; and

Whereas, All states have a need to ensure the viability of private medical practices and increased number of physicians; therefore be it

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

Fiscal Note: Not yet determined

Received: 10/22/14
RELEVANT AMA POLICY

D-405.988 The Preservation of the Private Practice of Medicine
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine’s career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice, with a progress report at the 2015 Annual Meeting; and (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option. (Res. 224, I-10; Appended: Res. 604, A-12; Reaffirmation I-13; Appended: Res. 735, A-14)
WHEREAS, Generic drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents that are expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling; and

WHEREAS, FDA classifies as therapeutically equivalent those products that meet the following general criteria: (1) they are approved as safe and effective; (2) they are pharmaceutical equivalents in that they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; (3) they are bioequivalent in that (a) they do not present a known or potential bioequivalence problem, and they meet an acceptable in vitro but not in vivo standard, or (b) if they do present such a known or potential problem, they are shown to meet an appropriate bioequivalence standard; (4) they are adequately labeled; (5) they are manufactured in compliance with current good manufacturing practice regulations; and

WHEREAS, The statistical methodology for analyzing these bioequivalence studies is called the two one-sided test procedure. Based on the opinions of US Food and Drug Administration (FDA) medical experts, a difference of greater than 20 percent for the (Cmax and AUC) tests was determined to be significant, and therefore, undesirable for all drug products; and

WHEREAS, The physician is ultimately responsible for prescribing medication because the FDA evaluation of therapeutic equivalence in no way relieves practitioners of their professional responsibilities in prescribing and dispensing such products with due care and with appropriate information to individual patients; and

WHEREAS, Professional care and judgment should be exercised in prescribing generic drugs to patients; therefore be it

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

Fiscal Note: Not yet determined

Received: 10/22/14
RELEVANT AMA POLICY

H-115.974 Prescription Labeling
Our AMA recommends (1) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription.  (2) That, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.  (3) When generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]".  (4) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed.  (BOT Rep. 1, A-95; Amended: CSA Rep. 2, I-99; Modified Res. 512, I-00; Reaffirmed: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmed: Sub. Res. 509, A-07)
Whereas, The medical community is changing dramatically, and cost, efficiency and quality are of the utmost concern; and

Whereas, Physicians practice in many different settings; and

Whereas, There are possible cost, quality and efficiency benefits from data integration in a larger health system or group practice benefit; however data integration is an expensive endeavor; and

Whereas, The role of the AMA and other medical associations is to support physicians in all models in which they choose to practice, including independent, private practice; and

Whereas, The AMA initiated previously innovation grants totaling $11 million to medical schools to encourage new medical education models; and

Whereas, Investment in possible new models of practice, data integration projects and/or other initiatives to improve quality and efficiency and reduce cost is in the best interest of our health care delivery system, profession of medicine and patients alike; therefore be it

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

Fiscal Note: Indeterminate.

Received: 10/09/14
Whereas, There is an extraordinarily large number of medical matters that rise to public attention in the media on a daily basis; and

Whereas, Public education about medical matters by the media is often very sketchy, biased by the particular inspiration of a reporter, columnist, or editorial writer, on the one hand, and publishers financial interests on the other; and

Whereas, Medical information is constantly evolving and changing, and one newspaper source about medical information is rarely adequate; and

Whereas, These days many legislators use the internet to obtain information; and

Whereas, The *AMA Morning Rounds* presents a very comprehensive summary of current medical issues and opinion in a reasonably balanced way; and

Whereas, This summary is understandable to the layman as well as the medical professional and contains links to the longer articles which makes it easier to obtain more details and identification of the original sources; therefore be it

RESOLVED, That our American Medical Association regularly send copies of *AMA Morning Rounds* to all members of Congress and their staff. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 10/09/14
Whereas, Our AMA needs to continue to demonstrate new value propositions to current, previous and potential new members; and

Whereas, American physicians continue to be critically concerned about their ability to continue to practice medicine to the best benefit of our patients in the current environment of increasingly onerous over-regulation; and

Whereas, It is AMA HOD and CEJA policy that physicians should be actively involved in advocacy on behalf of our patients and our profession, including making campaign contributions; and

Whereas, The AMA encourages physician contributions to AMPAC for the purposes of supporting campaign expenses for candidates for the U.S. Congress who will help further the AMA’s agenda; and

Whereas, AMPAC only supports candidates that have been recommended to it by state medical society political action committees (PACs); and

Whereas, AMPAC has grown to become one of the largest physician association PACs and continues to play a major role in the federal election process, including making independent expenditures; and

Whereas, AMPAC is highly regulated by the Federal Election Commission, with a maximum amount ($5000) that it can raise from each physician and cannot expend corporate contributions for federal election campaigns; and

Whereas, AMPAC has raised and spent over $3 million in the current election cycle and has and continues to be in the process of allocating these contributions strategically; and

Whereas, The landscape for PACs changed in 2010 when the US Supreme Court allowed the creation of what have become known as Super PACs; and

Whereas, A Super PAC can raise unlimited sums of money from corporations, associations and individuals--among others--and spend them only on independent expenditures to overtly advocate for or against political candidates; and
Whereas, The physician’s perspective, as adopted by the AMA House of Delegates, would be even more forcefully advanced if more funds were available to make the critical difference on behalf of AMPAC endorsed physician candidates engaged in close elections and other efforts; and

Whereas, In the current federal election cycle (as of October 19), 1,220 groups have organized as Super PACs (apparently none with medicine’s unique perspective) with total receipts of over $462 million and total independent expenditures of over $238 million; and

Whereas, The AMA has posted excess revenues over expenses of $40 million or more in each of the recent years, significantly increasing corporate reserves to over $450 million; therefore be it

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

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

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

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

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

RESOLVED, That the AMA Board of Trustees report back at the 2015 Annual Meeting with recommendations for the new AMA Super PAC. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/22/14
RELEVANT AMA POLICY

G-640.020 Political Action Committees and Contributions
Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries. (BOT Rep. II and Res. 119, I-83; Res. 175, A-88; Reaffirmed: Sunset Report, I-98; Sub. Res. 610, A-99; Res. 610, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11)

G-640.050 Preserving the AMA's Grassroots Legislative and Political Mission
Our AMA will ensure that all Washington activities, including lobbying, political education, grassroots communications and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner. (Res. 619, A-00; Reaffirmed: BOT Rep. 6, A-10; CCB/CLRPD Rep. 3, A-12)
REPORT OF THE SPEAKERS

Speakers’ Report 1-1-14

Subject: Rules for Campaign Parties

Presented by: Andrew W. Gurman, MD, Speaker; and Susan R. Bailey, MD, Vice Speaker

Referred to: Reference Committee F
(Robert L. Dannenhoffer, MD, Chair)

Prior to the 2014 Annual Meeting, paragraph 6 of Policy G-610.020, Election Campaigns, read as follows:

AMA policy on election campaigns includes the following: (6) A coalition or a state or specialty delegation may finance only one big party at the Annual Meeting irrespective of the number of candidates from the society or coalition. This rule limits a candidate to only one big party at the Annual Meeting whether financed by a coalition or a state or specialty delegation. This rule also limits a state or specialty society or coalition to one big party irrespective of the number of candidates from that society or coalition. At these events, alcohol may be served only on a cash or no-host bar basis;

Resolution 602-A-14 proposed an addition to the existing policy that would allow societies to sponsor multiple parties, so long as any particular candidate was featured at only one party. Following its open hearing, Reference Committee F proffered an amendment to the policy by substitution, which was adopted. The language of Policy G-610.020(6) now reads (the full policy can be found in Appendix A):

A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) standing in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate’s name on them.

The amendment by substitution effectively rescinded the language dealing with alcohol. The rescission appears to have been inadvertent, however, because testimony in the reference committee addressed concerns about party sponsorship. No comments related to the serving of alcohol were heard, and in fact, the language of Resolution 602 as originally proposed had retained the restrictions on alcohol service. The item was not debated on the floor of the House, having been adopted on the consent calendar.

The limits on serving alcohol had been adopted at the 1997 Annual Meeting based on a recommendation from the Special Committee on Campaigns and Elections (Appendix B), which had been formed to address concerns about the expense of AMA campaigns. The committee concluded that members of the House appreciated the collegiality of social functions and the opportunity to become better acquainted and discuss business with fellow delegates and alternate delegates, but that there was “much concern expressed about the cost of these social events, especially the cost of serving alcoholic beverages…. The Special Committee now believes that
given the political and financial climate, a firm rule must be established that is easily enforced and applies to everyone equally.”

The rule that eventuated was simple and easily implemented, and it served our AMA well for over 15 years. Moreover, the challenges of election campaigns are not dissimilar to those from 1997. Your Speakers believe that the removal of language relating to alcohol at campaign parties should be reinstated and therefore propose the following recommendation. As an aside, we would note that the rule applies only to election parties and not to other traditional activities that are not campaign-related.

RECOMMENDATION

Your Speakers recommend that Policy G-610.020, paragraph 6, be amended by addition to read as follows:

A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) standing in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate’s name on them. At these events, alcohol may be served only on a cash or no-host bar basis; (Modify Current HOD Policy)

and that the remainder of this report be filed.

Fiscal note: Less than $500
AMA policy on election campaigns includes the following:
(1) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates; (2) A campaign manual containing information on all candidates for election shall continue to be developed and distributed; (3) Campaign expenditures and activities should be limited to prudent and reasonable levels necessary for adequate candidate exposure to the delegates. The Speaker of the House should meet with all announced candidates and campaign managers at each meeting of the House of Delegates to agree on general campaign procedures; (4) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged, and there shall be no large campaign receptions, luncheons, or other formal campaign activities. This rule does not preclude distribution of a declaration of candidacy on the last day of the Annual Meeting, last day of the Interim Meeting, or one announcement of candidacy by a mailing prior to the Interim Meeting. An announcement of candidacy includes only the candidate’s name, photograph, email address, URL, the office sought and a list of endorsing societies. This rule prohibits campaign parties at the Interim Meeting and the distribution of campaign literature and gifts at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election at the next Annual Meeting to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate’s opinions and positions on issues; (5) The AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials sent to the House and on the ballot as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose; (6) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) standing in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate’s name on them; (7) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited. Displays of campaign posters, signs, and literature in public areas of hotels in which Annual Meetings are held detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties and campaign literature may be distributed in the non-official business folder for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates; (8) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings; (9) Campaign gifts can be distributed only at the Annual Meeting in the non-official business folder and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to Delegates and Alternate Delegates in advance of the meeting. Campaign memorabilia are limited to either a button, pin, sticker, or other low-cost item, the maximum cost of which shall be determined by the Speaker of the House. No other campaign memorabilia shall be distributed at any time; (10) The Speaker’s office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker); (11) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society; (12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and (13) Our AMA (a) requires completion of Disclosure of Affiliation forms by all candidates for election to our AMA Board of Trustees and Councils prior to their election; and (b) will expand accessibility to completed Disclosure of Affiliation information by posting such information on the “Members Only” section of the AMA website before election by the House of Delegates.
APPENDIX B - Report of the Special Committee on Campaigns and Elections, from the Proceedings for the 1997 Annual Meeting

The following report was presented by Joseph T. Ostroski, MD, Chair:

CAMPAIGN-RELATED SOCIAL FUNCTIONS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

At the 1996 Interim Meeting, the House of Delegates revised certain rules pertaining to the conduct of campaigns for AMA office. The House acted upon recommendations of a special committee appointed by the Speaker to observe the campaign process and solicit suggestions from the delegates for making revisions. In addition the Speaker asked the special committee to sit as Reference Committee I and conduct an open hearing and prepare a report for House of Delegates consideration. Members of the Special Committee on Campaigns and Elections are:

Joseph T. Ostroski, MD, Florida, Chair
Cathy O. Blight, MD, Michigan
Jimmie A. Gleason, MD, Kansas
Charles D. Hollis, MD, Georgia
Jack P. Strong, MD, US and Canadian Academy of Pathology, Inc.

While modifying several campaign rules, the House of Delegates was uncertain about the best course of action to take regarding campaign related social functions. The House voted to continue the special committee for the sole purpose of considering this issue and referred the Special Committee’s Recommendation 5 back to the committee for a report at the 1997 Annual Meeting. This action had the effect of keeping unchanged the rule on campaign parties adopted in 1992. The Special Committee’s Recommendation 5 states:

“Social functions at AMA Annual and Interim Meetings may be continued without bands, entertainment, lavish decorations and formal reception lines. Adoption of one or more of the following options may be considered by sponsors of social functions seeking to limit expenditures: utilizing a cash or no-host bar; limiting alcoholic beverages to beer and wine; eliminating all alcoholic beverages.”

The Special Committee believes that there is overwhelming sentiment to continue both campaign and noncampaign social functions at meetings of the House of Delegates. Members of the House of Delegates appreciate the opportunities to enjoy collegiality, become better acquainted with delegates and alternate delegates, to discuss issues on the House agenda, and to share experiences. The Special Committee also heard much concern expressed about the cost of these social events, especially the cost of serving alcoholic beverages. The discussion only involved the cost of these beverages and did not include any moral issues about the appropriateness of having alcohol available at social events. Various suggestions were offered to control these costs without eliminating social functions altogether.

The Special Committee now believes that given the political and financial climate, a firm rule must be established that is easily enforced and applies to everyone equally. The Committee wants the candidates’ sponsoring societies to have a large measure of flexibility in determining what kind, if any, social activities are arranged on behalf of their candidates. One candidate may prefer to spend a large share of the available budget on food, another on entertainment, and another on decorations. The Committee believes, however, costs can be curtailed by requiring all campaign social events that plan to serve alcohol to do so only on the basis of a cash or no-host bar. This new rule would apply only to campaign related social events and would not apply to any receptions, dinners, or parties of a non-campaign nature organized by the AMA or units in the Federation. Also, this rule would apply to social functions held in public meeting rooms of the hotel and would not apply to social functions held in the hotel suites, commonly called “Open Hospitality.”
RECOMMENDATION:

The Special Committee on Campaigns and Elections recommends:

1. That the following rule on campaign related social functions be adopted to become effective at the 1998 Annual Meeting of the House of Delegates:
   There will be only one big party at the Annual Meeting financed by a coalition or a state or specialty delegation irrespective of the number of candidates from that society or coalition. At these events, alcohol may be served only on a cash or no-host bar basis.

2. That the rule on Campaign Related Social Functions be reviewed in two years and modified as necessary.
INTRODUCED BY:

Alabama

SUBJECT:

Board Recertification to Maintain Hospital Staff Privileges

REFERRED TO:

Reference Committee J
(Melissa J. Garretson, MD, Chair)

Whereas, Most hospitals require physicians to be board eligible or board certified to be on the hospital medical staff; and

Whereas, All 24 member boards of the American Board of Medical Specialties now give time limited board certification which are usually good for 8-10 years; and

Whereas, Physicians now reaching 60 years of age may find themselves taking their boards for the 4th or 5th time; and

Whereas, The initial board certification is very important to demonstrate a wide breadth of knowledge in the individual physician’s field of practice, however most physicians over a period of time change their practices to fit their skills, interests and local medical environment so that subsequent board exams may not be measuring what that particular physician does anymore; and

Whereas, Physicians who are required to take board exams that are not applicable to their practice anymore are put in positions of spending large amounts of money to travel for board review courses that are given just a few weeks prior to the examination so that they can pass a meaningless test and prove that they are a good doctor; and

Whereas, This is just now becoming a problem because previously physicians who are mostly older than age 60 had lifelong board certification without expiration; and

Whereas, Many excellent physicians now reaching the age of 60 may find themselves being kicked off medical staffs if they fail their board recertification exam or simply get tired of taking it for the 4th or 5th time; and

Whereas, We will be losing many fine physicians because of this out of date part of our hospital bylaws at a time when we need more physicians and not less; and

Whereas, There are more accurate ways other than a 100 question test to show that a physician has kept up to date and maintained adequate knowledge to practice his profession and to be of benefit to his patients; and

Whereas, Our AMA has policy on board certification (H-230.986) and recertification (H-230.997) however we need to be more active in developing model staff bylaw changes to allow this policy to work in our hospitals and protect the physicians with time limited board certificates: therefore be it
RESOLVED, That our American Medical Association develop model changes to hospital staff bylaws that will address the problem of requiring board recertification to remain on staff (Directive to Take Action); and be it further

RESOLVED, As our AMA develops model hospital staff bylaw changes with regards to board recertification, that several things be considered such as: 1) board certification may continue to be required for granting of initial hospital staff privileges, and 2) subsequent board recertification may be just one of several options to retain staff privileges with other options or combination of being things such as participating in their specialty’s maintenance of certification process, participating in their state’s CME requirements, and serving on the medical staff in a continuous fashion with appropriate positive peer review and without any negative patient care issues (Directive to Take Action); and be it further

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

Fiscal Note: Minimal - less than $1,000.

Received: 9/21/14

RELEVANT AMA POLICY

H-230.986 JCAHO Recognition of Specialty Boards Recognized by American Board of Medical Specialties and AMA and AOA
The AMA believes that medical staffs should have flexibility in determining which, if any, specialty board certification will be used as a criterion to delineate clinical privileges. (BOT Rep. XX, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CME Rep. 7, A-07)

H-230.997 Recertification and Hospital or Health Plan Network Privileges
(1) The fact that a board certified practitioner fails to undergo the recertification examination shall not be adequate reason to modify or withhold hospital privileges or health plan network status from a physician. (2) Modification or withholding of hospital privileges or health plan network status shall be purely on the basis of assessment of performance. (Res. 26, A-77; Reaffirmed: CLRDP Rep. C, A-89; Reaffirmed: Sunset Report, A-00) (Res. 26, A-77; Reaffirmed: CLRDP Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: Res. 727, A-06)
Whereas, Many elderly suffer from hearing loss which diminishes their quality of life and communication with others leading to social withdrawal, loneliness or isolation; and

Whereas, Hearing loss over time can impair the brain's ability for word recognition, result in loss of cognitive skills, increase the rate of cognitive decline and has been shown to increase the risk of developing dementia; and

Whereas, Hearing aids provide other health benefits to our elderly patients in helping maximize sensory input and potentially decreasing fall risk; and

Whereas, Medicare expenditures for dementia-related care and falls among the elderly is costly; and

Whereas, Medicare does not cover the cost of hearing aid devices, but does cover other medical devices; and

Whereas, Many elderly have limited economic resources to pay for hearing aids which are costly; therefore be it

RESOLVED, That our American Medical Association support Medicare coverage of hearing aid devices, including external and implantable hearing aid devices. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 9/26/14
Whereas, The AMA monitors certain activities of medically related corporations, usually in retrospect, unless somehow alerted by constituents; and

Whereas, Third parties have historically targeted doctors, limited costs or limited the treatment and thus limit overall autonomy in practice of medicine. A recent decline in reimbursement nationwide has fueled a pattern of acquisitions not seen before in the history of medicine. To obtain control of nearly all aspects of medical care, hospitals normally compete for patients by geographic location. Some gain unlawful advantage by control where patients are treated, what tests can be done and even by whom patients are treated by with only regard to dollars and not quality of care rendered. These monopolies have been disguised in many ways and called many things; but the bottom line is revenue. These hospitals strengthen in communities by:

1) Buying medical groups
2) Forming co-terminus agreements with certain doctors
3) Selling hospital-only insurance products (HMO included); and

Monopolies thus arise when a company controls the majority of a market, thus stifling competitive services in medical care. Business disputes frequently "settle-out" or merge to create a larger entity which has a stifling effect on competition, therefore be it

RESOLVED, That our American Medical Association study the effects of monopolistic activity by healthcare entities that may have a majority of market share in a region on the patient-doctor relationship (Directive to Take Action); and be it further

RESOLVED, That our AMA develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physicians and physician practices who are confronted with monopolistic activity by healthcare entities. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 9/26/14
Whereas, Approximately 35 million patients participate in Medicare Part D prescription drug plans; and

Whereas, An estimated 25% of those Medicare beneficiaries will have total drug costs exceeding the threshold from the covered phase to the gap (donut hole) phase; and

Whereas, The gap (donut hole) phase will not be closed until the year 2020; and

Whereas, The payment processing rules applicable to drug costs that straddle between the coverage phase to the gap phase are complicated and fact sensitive; and

Whereas, The straddle drug pricing rules are difficult for seniors to understand; and

Whereas, Pharmacies must take care to ensure that seniors are not overcharged during the gap phase; therefore be it

RESOLVED, That our American Medical Association study the straddle drug pricing rules to ensure that costs are not being inappropriately shifted to Medicare beneficiaries during the gap phase (Directive to Take Action); and be it further

RESOLVED, That our AMA shall report back the results of its study at the June 2015 Annual Meeting, including an assessment of whether pharmacies are in compliance with the Affordable Care Act’s cost sharing requirements during the gap phase. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/06/14
WHEREAS, Maintenance of certification (MOC) is an expensive, onerous process increasingly used to deny physicians hospital privileges and insurance participation; and

WHEREAS, No high quality evidence exists to show maintenance of certification benefits patients or physicians; and

WHEREAS, The American Board of Medical Specialties (ABMS) states “Fact: ABMS recognizes that regardless of the profession – whether it is health care, law enforcement, education or accounting – there is no certification that guarantees performance or positive outcomes.”; and

WHEREAS, The AMA has now actively resolved to oppose MOC requirements for practice payments; and

WHEREAS, Legislation has been introduced in the state of New York to prohibit the use of MOC participation to be linked to licensing, privileging or payments; therefore be it

RESOLVED, That our American Medical Association release a yearly report regarding the maintenance of certification process. (Direction to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 9/26/14
RELEVANT AMA POLICY

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 each 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 permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (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)

D-275.960 An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure
1. Our AMA will encourage the American Board of Medical Specialties (ABMS) and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. 2. Our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in discussions regarding their implementation, and report back to the House of Delegates on these issues. 3. Our AMA will (a) work with theABMS and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and (b) work with the ABMS to explore alternatives to the mandatory high-stakes examination. 4. Our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting
MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. 5. Our AMA will work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician’s current practice. 6. Our AMA will solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians’ practices, including but not limited to: physician workforce, physicians’ practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015. 7. Our AMA: (a) supports ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; (b) supports specialty board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; (c) encourages the ABMS specialty boards to enhance the consistency of such programs across all boards; and (d) will work with specialty societies and specialty boards to develop tools and services that facilitate the physician’s ability to meet MOC requirements. 8. Our AMA Council on Medical Education will continue to review published literature and emerging data as part of the Council’s ongoing efforts to critically review maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) issues. 9. Our AMA will continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians’ practices, including, but not limited to physician workforce, physicians’ practice costs, patient outcomes, patient safety, and patient access. 10. Our AMA will work with the American Board of Medical Specialties (ABMS) and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification. 11. Our AMA will work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician’s decision to retire and have a direct impact on the US physician workforce. (CME Rep. 10, A-12; Modified: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 610, A-14; Appended: CME Rep. 6, A-14)
Whereas, Tobacco smoking is a determined killer; and

Whereas, On August 14, 2014, The New England Journal of Medicine Perspective article entitled “Is it Time for a Tobacco-free Military?” by E. A. Smith, and others, makes us aware that “Tobacco harms military personnel, impairs readiness, and incurs unnecessary costs...”1; and

Whereas, Public awareness, health education, and policies enforcing tobacco-free zones has resulted in a smoking-rate decrease in the United States; and

Whereas, Tobacco usage has been reported to have harmful effects on readiness, stress levels, fitness, and the general health of smokers and non-smokers (due to the effects of second-hand smoke); and

Whereas, The military services already have begun to promote tobacco-free basic training and reviews seeking to end the sale of tobacco in military installations2; and

Whereas, There is a military report suggesting that stress levels are higher in smokers than in non-smokers2; and

Whereas, The direct financial costs as well as the indirect health care costs strain the military services as well as the service members; and

Whereas, It is the responsibility of the United States military forces to protect, educate, and care for individual service members whose responsibility is to protect our country and its citizens; and

Whereas, The policy of not using tobacco in the military is consistent with other requirements regarding weight, fitness, and general health1; therefore be it

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

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

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

Fiscal Note: Minimal - less than $1,000.

Received: 10/07/14


WHEREAS, The American Academy of Pediatrics recommends that children be placed in rear-facing child safety seats until age two; and

WHEREAS, Rear-facing has been proven to be five times safer than forward-facing for infants and young toddlers; and

WHEREAS, Manufacturers recognize the American Academy of Pediatrics recommendations in their child safety seat instructions; and

WHEREAS, The public has not been educated on the importance of rear-facing restraint until age two; and

WHEREAS, Greater public awareness of the importance of rear-facing restraint until age two will save lives and reduce injury; therefore be it

RESOLVED, That our American Medical Association support efforts to require child safety seat manufacturers to include information about the importance of rear-facing safety seats until two years of age as recommended by the American Academy of Pediatrics. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/09/14
Whereas, Generic pharmaceuticals fill 84% of prescriptions dispensed in the US but account for just 27% of the total drug spending according to the Generic Pharmaceutical Association; and

Whereas, 80% of active pharmaceutical ingredients are imported to the US and 40% of finished drugs according to the US Food and Drug Administration (FDA) though there is no good information on the percent of finished generic drugs imported; and

Whereas, Even US headquartered generics manufacturers are rushing to expand overseas manufacturing, especially to India; and

Whereas, There have been a number of voluntary recalls and a lack of close monitoring by the FDA or the monitoring agency in some foreign countries, especially India and China; therefore

be it

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

RESOLVED, That our AMA advocate for including the source country of the active pharmaceutical ingredients and of the manufacture of the finished drugs on the labels of all medications available to American consumers until such time as US monitoring and foreign manufacturing are deemed adequate. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/09/14

RELEVANT AMA POLICY

D-100.977 Pharmaceutical Quality Control for Foreign Medications
Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients. (Res. 508, A-08)
Whereas, In an era of increasing regulatory and administrative burden being placed upon practicing physicians, the requirements within the Maintenance of Certification (MOC) program are an additional time intensive process that results in further disruption in the availability of physicians to care for patients; and

Whereas, The certification requirements within MOC are costly in terms of direct financial expenditures and indirect costs through productivity losses, both of which negatively impact the fiscal status of practicing physicians; and

Whereas, The American Board of Medical Specialties (ABMS) is a private organization who now has the equivalent of monopoly power over board certification; and

Whereas, Allowing this private monopoly to continue increases costs, hampers innovation, and potentially violates federal IRS, antitrust and interstate commerce laws; and

Whereas, Physicians understand the importance of continuing medical education and staying up-to-date on the latest medical developments; and

Whereas, There are no outcome-based studies to validate that the MOC process improves health care delivery and as such MOC fails any cost-benefit analysis; therefore be it

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

Fiscal Note: Not yet determined

Received: 10/22/14
RELEVANT AMA POLICY

D-275.960 An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure
1. Our AMA will encourage the American Board of Medical Specialties (ABMS) and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. 2. Our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in discussions regarding their implementation, and report back to the House of Delegates on these issues. 3. Our AMA will (a) work with the ABMS and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and (b) work with the ABMS to explore alternatives to the mandatory high-stakes examination. 4. Our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. 5. Our AMA will work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician’s current practice. 6. Our AMA will solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians’ practices, including but not limited to: physician workforce, physicians’ practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015. 7. Our AMA: (a) supports ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; (b) supports specialty board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; (c) encourages the ABMS specialty boards to enhance the consistency of such programs across all boards; and (d) will work with specialty societies and specialty boards to develop tools and services that facilitate the physician’s ability to meet MOC requirements. 8. Our AMA Council on Medical Education will continue to review published literature and emerging data as part of the Council’s ongoing efforts to critically review maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) issues. 9. Our AMA will continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians’ practices, including, but not limited to physician workforce, physicians’ practice costs, patient outcomes, patient safety, and patient access. 10. Our AMA will work with the American Board of Medical Specialties (ABMS) and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification. 11. Our AMA will work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician’s decision to retire and have a direct impact on the US physician workforce. (CME Rep. 10, A-12; Modified: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 610, A-14; Appended: CME Rep. 6, A-14)

H-275.923 Maintenance of Certification / Maintenance of Licensure
Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the
impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. 2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. 5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. 6. Continue to participate in the NAPC forums. 7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 8. 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 post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. 10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. 13. Our AMA opposes any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), that does not protect physician privacy, and that is used to promote policy initiatives above physician competence. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11; 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; Reaffirmed in lieu of Res. 610, A-14; Appended: Res. 319, A-14)

D-275.971 American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements
1. Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements. 2. Our AMA will actively work to enforce existing policies to reduce current costs and effort required for the maintenance of certification and to work to control future charges and expenses. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 319, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed in lieu of Res. 919, I-13)
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 each 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 permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (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)
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: __________
(I-14)

Introduced by: Virginia

Subject: REGULATION OF ELECTRONIC NICOTINE DELIVERY DEVICES

Referred to: Reference Committee
______________M.D., Chair)

WHEREAS, electronic nicotine delivery devices, also known as electronic cigarettes or e-cigs, are recently developed products which allow the inhalation of nicotine without the burning of tobacco leaves, and

WHEREAS, the inhalation of aerosolized vapors, also known as “vaping,” is becoming increasingly popular amongst all sections of the community; especially children, where the use has doubled in high school students over the last calendar year, and

WHEREAS, these products are being marketed to children through advertising campaigns and are available in candy-like flavors such as bubblegum, chocolate and “cherry crush,” and

WHEREAS, these devices may act as “gateway” devices to introduce children to other tobacco products, and

WHEREAS, the long term safety of these devices is unknown, and

WHEREAS, the use of these products may have a role in assisting tobacco smokers to discontinue their habit, and

WHEREAS, the Food and Drug Administration is considering the potential of regulating these products in the same manner as other tobacco products, therefore be it

RESOLVED, that the American Medical Association (AMA) support legislation and FDA action to tax, label and regulate electronic nicotine delivery devices (ENDS) as tobacco products and drug delivery devices; and be it further

RESOLVED, that the AMA support state and federal legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to the same restrictions as that of tobacco products; and be it further

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

RESOLVED, that the AMA support local, state, and national efforts to require secure, child-proof, tamper-proof packaging and design of ENDS; and be it further
RESOLVED, that the AMA support local, state, and national efforts to require enhanced labelling that warns of the potential consequences of ENDS use, restriction of ENDS marketing as tobacco cessation tools, and restriction of the use of characterizing flavors in ENDS; and be it further.

RESOLVED, that the AMA encourage basic, clinical, and epidemiological research concerning ENDS.
WHEREAS, the American Medical Association (AMA) has published The Balanced Budget Act of 1997 which capped the number of resident physicians each teaching hospital could claim for reimbursement under Medicare, and

WHEREAS, the AMA has published that the U.S. will face a shortage of 62,900 physician in 2015 that will increase to 130,000 across all specialties by 2025, and

WHEREAS, the AMA has projected in 2014 that 30 million Americans will gain health care coverage under the Affordable Care Act, and

WHEREAS, the AMA has published that in the U.S. approximately 20 newly accredited medical schools and increasing enrollment at existing medical programs will expand total medical student enrollment by 30 percent by 2017, and

WHEREAS, the AMA has published that 528 U.S. medical graduates did not match into a residency this year and double the number that did not match in 2012, and

WHEREAS, the AMA has published that by 2015 the number of medical school graduates is predicted to exceed residency positions, and

WHEREAS, due to the 2013 sequestration cuts to the Medicare budget it is unknown how federal graduate medical education funding will be affected, therefore be it

RESOLVED, that our AMA encourage and advocate for private and alternative sources of funding for GME educational opportunities.

RESOLVED, that the AMA will support when appropriate and encourage the AMA to advocate for additional sources of funding for private payers to support both direct and indirect costs of graduate medical education and that the AMA encourage the AMA to explore funding for additional residency slots, and be it further

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

Subject: OPPOSITION OF MAINTENANCE OF CERTIFICATION AS CONDITION FOR LICENSURE, CREDENTIALING, OR REIMBURSEMENT

Referred to: Reference Committee
(M.D., Chair)

WHEREAS, physicians are among the nation’s most rigorously trained professionals, and
WHEREAS, requirements for maintaining the skills needed to serve their patients vary greatly depending upon their patient population and chosen set of treatments offered, and
WHEREAS no one is in a better position than the individual physician to determine how best to maintain the needed skills, and
WHEREAS, other professionals such as lawyers are not subjected to mandatory recertification requirements, and
WHEREAS, certification requirements are costly and time-intensive, requiring significant disruptions in availability of the physician for patient care, and
WHEREAS, there is no evidence that mandatory recertification results in any improvement in patient care, and
WHEREAS, there are significant conflicts of interest in agencies approved to set the requirements, and
WHEREAS, constant externally imposed study requirements tend to enforce conformity rather than encourage the independence of thought essential for professionals, and
WHEREAS, mandatory recertification is likely to reduce access to care by encouraging retirement of physicians who are providing excellent, much needed care, and
WHEREAS, mandatory recertification empowers government and disenfranchises patients and professionals, and
WHEREAS, that the Medical Society of Virginia supports the following American Medical Association Policies:

H-275.950 Board Certification
Our AMA (1) reaffirms its opposition to the use of board certification as a requirement for licensure or reimbursement; (2) seeks an amendment to the new Medicaid rules that would delete the use of board certification as a requirement for reimbursement and would address the exclusion of internal medicine, emergency medicine, or other specialties; and (3) opposes mandatory MOC as a condition of medical licensure, and encourage physicians to strive constantly to improve their care of patients by the means they find most effective. (Res. 143, A-92; Reaffirmed by Res. 103, A-98; Reaffirmation A-00; Reaffirmed: CME Rep. 16, A-09; Appended: CME Rep. 6, A-14)
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 each 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 permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. The AMA affirms the current language regarding continuing medical education (CME): “By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A).”
10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians.

RESOLVED, that the AMA oppose maintenance of certification as a mandated requirement for licensure, credentialing, or reimbursement.
WHEREAS, prior to 1 April, 2005, medical residents were considered “students” for tax purposes, which was amended to “employees” at that time, and
WHEREAS, FICA taxes paid prior to 1 April, 2005 were withheld by many institutions, and
WHEREAS, the deadline, established by federal statute to file a claim for taxes has expired, and
WHEREAS, the number of medical residents who actually received a refund is unknown, and
WHEREAS, potentially thousands of medical residents have erroneously paid taxes and are justly due a refund, and
WHEREAS, the American Medical Association (AMA) is rightfully concerned about the possibility of helping its members apply for claims for FICA tax refunds, therefore be it
RESOLVED, that the AMA investigate the number of unclaimed FICA tax refunds by medical residents and if that number is significant, and be it further
RESOLVED, that if the number of unclaimed FICA tax refunds is significant, the AMA will seek federal legislation to extend the deadline to apply for FICA tax refunds prior to 2005.
WHEREAS, during the last few years health insurance companies have started to issue virtual credit card payments to physicians as reimbursement for medical care, allowing the insurance company cost savings since they no longer have to pay electronic funds transfer fees or process paper checks, and

WHEREAS, vendors who issue these virtual credit cards charge physicians a transaction fee when these are redeemed of up to five percent, and this fee is in addition to the usual discounted fee for service accepted by most physicians, and

WHEREAS, virtual credit card payments allows insurers to shift the cost of transferring funds to the medical practice, therefore be it

RESOLVED, that the AMA Board of Trustees considers legislation on behalf of physicians that any credit card transaction/bank fees are paid by the insurer and not the health care provider.