D-10.000 Accident Prevention/Unintentional Injuries
(See also: Accident Prevention: Motor Vehicles; Firearms: Safety and Regulation; Sports and Physical Fitness)

D-10.993 Grade-Level Railroad Crossings

Our AMA:

(1) advocates a study evaluating methods of limiting grade-level railroad crossing accidents;

(2) endorses the concept that, wherever possible, grade-level railroad crossings be eliminated in order to avoid automobile-related accidents;

(3) encourages the construction of non-grade-level crossings whenever new crossings are necessary; and

(4) supports federal funding for the construction of new non-grade-level railroad crossings throughout the country. (Res. 427, A-07)

D-10.994 Preventing Scooter Injuries

Our AMA will: (1) encourage the Centers for Disease Control and Prevention and other appropriate public and private agencies to collect surveillance data on scooter riding, use of protective gear, and scooter injuries, and to support education and research on the prevention of scooter injuries; (2) work with other interested health organizations and public health agencies to prepare educational materials on the safe use of scooters and the prevention of scooter injuries for use with patients and the public at large; and (3) encourage medical specialty societies, state and local medical societies, the AMA Alliance, and state and local Alliances, to support or participate in efforts to prevent injuries caused by scooters. (Res. 411, I-00)

D-10.995 Bungee Cord Products

Our AMA will notify the Consumer Product Safety Commission of the potential for eye injuries associated with the use of bungee cords. (Res. 405, A-00)

D-10.996 Automatic Garage Door Safety and Education

Our AMA will request the Consumer Product Safety Commission to educate the public about the risk of injury associated with the operation of automatic garage doors and disseminate guidelines for their safe operation. (Sub. Res. 422, A-99)

D-10.997 Safety at Railroad Crossings

Our AMA will ask the Federal Railroad Administration to explore new ways of improving safety at railroad crossings. (Sub. Res. 417, A-99)

D-10.998 In-Line Skating

(1) Our AMA will encourage federal agencies and industries to support research on patterns of equipment use and frequency of protective equipment use for in-line skating.

(2) Our AMA will work with the Consumer Product Safety Commission, Centers for Disease Control and Prevention, national in-line skating organizations, and medical specialty societies, Alliance and Federation to encourage in-line skaters to wear protective equipment.

(3) Our AMA will encourage medical specialty societies and state and local medical societies to advocate for state and local legislation to improve the safety of in-line skating through:

(a) the use of appropriate protective equipment (especially helmets);
(b) the designation of protected areas for in-line skating;
(c) prohibitions against hitching a ride behind a moving vehicle;
(d) the assurance that protective equipment is available at skating rental shops; and
(e) the provision of training and educational materials.

(4) Such legislation should include a surveillance component to monitor compliance. (CSA Rep. 19, A-99)

D-15.000 Accident Prevention: Motor Vehicles
(See also: Accident Prevention)

D-15.994 Prevention of Motor Vehicle-Related Backover Injuries/Deaths

Our AMA supports educational initiatives and evidence-based measures to prevent motor vehicle-related backover injuries/deaths. (Res. 434, A-05)

D-15.995 ATV Safety

Our AMA will seek:

(1) federal legislation to require sellers of all terrain vehicles (ATVS) in the United States to promote the sale of and use of suitable helmets to be used when operating or riding as a passenger on ATVs; and

(2) federal and state legislation and/or regulation to maximize safety of ATV operation including but not limited to (a) wearing suitable helmets and protective gear when operating or riding as a passenger on an ATV, (b) providing some safety instruction and training to all operators of ATVs, and (c) ensuring appropriate licensure for all operators of ATVs. (Res. 433, A-05)

D-15.996 Impaired Drivers

Our AMA shall: (1) draft model state legislation allowing physicians voluntarily to report to the Department of Motor Vehicles or like agency individuals afflicted with an impairment that may prevent them from safely operating a motor vehicle, and protecting from liability physicians who report, or based on their best medical judgment do not report, such information to the Department in good faith; (2) continue to identify materials that will be beneficial in informing and educating physicians and patients on motor vehicle operation and impairment, including the development by 2003 of a practical guide for physicians on assessing and counseling drivers; and (3) continue to monitor, collect, and disseminate information on state requirements for reporting of impaired drivers to appropriate regulatory agencies. (BOT Rep. 8, A-02)

D-15.997 Diversion Programs For Impaired Drivers

Our AMA will study diversion programs for impaired drivers with treatable conditions, including their impact on physician liability. (Sub. Res. 9, I-99)

D-15.999 Options for Improving Motorcycle Safety

Our AMA: (1) encourages the National Highway Traffic Safety Administration to work with medical and public health organizations, national motorcycle rider organizations, state motor vehicle licensing agencies, law enforcement officials, and the motorcycle industry to develop a comprehensive national motorcycle safety plan that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; alcohol use among motorcyclists and other motor vehicle drivers; measures to increase the visibility of motorcyclists and motorcycles to other drivers; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current and proposed safety measures; and

(2) encourages physicians to (a) be aware of motorcycle risks and safety measures and (b) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs. (CSA Rep. 6, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

D-20.000 Acquired Immunodeficiency Syndrome (AIDS)
(See also: Blood, Public Health)

D-20.989 HIV and Public Health Prevention Services

Our AMA will work with the Centers for Disease Control and Prevention to develop Comprehensive Risk Counseling and Services to be offered to persons reported with HIV infections that are modeled after those provided for persons reported with sexually transmitted diseases. (Sub. Res. 504, A-08)

D-20.990 Global HIV/AIDS Prevention

Our AMA extends its support of comprehensive family-life education to foreign aid programs to prevent the spread of HIV/AIDS and other sexually transmitted diseases. (Res. 439, A-08)

D-20.991 Ethical and Legal Issues in Responding to Occupational HIV Exposure

Our AMA will share its model state legislation, "Health Care Worker AIDS Testing and Consent Act," with the medical societies of states that have not yet adopted similar legislation. (BOT Rep. 1, A-07)

D-20.992 Improving Access to Rapid HIV Testing: An Update

Our AMA:
(1) supports the Centers for Disease Control and Prevention's (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings;
(2) will continue to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; and
(3) will identify legal and funding barriers to the implementation of the CDC's HIV testing recommendations and develop strategies to overcome these barriers. (CSAPH Rep. 2, I-06)

D-20.993 Promotion of Rapid HIV Test

Our AMA will: (1) work with any and all local and state medical societies, and other interested US and international organizations, to increase access to and utilization of Food and Drug Administration-approved rapid HIV testing in accordance with the quality assurance guidelines for rapid HIV testing developed by the Centers for Disease Control and Prevention. Additionally, pre- and post-test counseling should be performed in accordance with guidelines established by the CDC; and (2) report back on its efforts to increase access to FDA-approved HIV rapid testing at the 2006 Interim Meeting. (Res. 511, A-05)

D-20.994 Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use

Our AMA: (1) urge the Centers for Disease Control and Prevention to maintain the on-line fact sheet and curriculum on HIV and STD prevention education involving condom use and to continue to augment the fact sheet as new information is developed; and (2) issue a letter to Secretary of the U.S. Department of Health and Human Services to express grave concern that funding, promotion, and institutional support for safer sex programs, including those that involve condom use, not be compromised. (Res. 732, I-02)

D-20.995 Universal, Routine Screening of Pregnant Women for HIV Infection

Our AMA will support the recommendations of the Institute of Medicine's report on perinatal HIV transmission, "Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States." (CSA Rep. 1, I-01)

D-20.996 Prophylaxis for Medical Students Exposed to Bloodborne Pathogens

Our AMA: (1) asks the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to remind its surveyors of the importance and expectation of development of and adherence to appropriate policies, e.g., prophylaxis related to pre- or post-exposure to bloodborne pathogens, in healthcare organizations where medical students are involved; and (2) send to medical school deans, a letter asking them to make certain that medical students are fully informed on medical school policies concerning exposure to bloodborne pathogens so that students are aware of the recommended course of action available to them. (BOT Rep. 21, A-00)

D-20.997 Preventing Needlestick Injuries in Health Care Settings

Our AMA will work with state and medical specialty societies to: (a) disseminate the information in the new Occupational Safety and Health Administration (OSHA) bloodborne pathogens standard compliance directive to physicians; and (b) assist physicians in implementing the requirements of the OSHA bloodborne pathogens standard that are appropriate for their medical practices. (CSA Rep. 1, A-00; Reaffirmation I-03)

D-20.998 Bloodborne Pathogen Transmission to and from Health Care Workers

Our AMA requests that the Centers for Disease Control and Prevention review its guidelines for HIV/HBV-infected health care workers with specific consideration of adopting a significant risk standard and consideration of separate guidance for HIV-infected health care workers and HBV-infected health care workers. (CSA Report 10, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

D-25.000 Aging
(See also: Accident Prevention: Motor Vehicles; Drug Abuse; Pregnancy)

D-25.998 Building the Health Care Workforce for an Aging America

Our AMA will work with appropriate specialty societies to review the recommendations of the April 2008 Institute of Medicine Report, "Retooling for an Aging America: Building the Health Care Workforce," and make recommendations (action required prior to the 2008 Interim Meeting) regarding steps to support and implement specific IOM recommendations. (Res. 429; A-08)

D-25.999 2005 White House Conference on Aging: Review and Implementation of Recommendations

Our AMA will work with appropriate specialty societies to review the resolutions of the 2005 White House Conference on Aging to identify those with relevance to health care and make recommendations to the Board of Trustees (action required prior to the 2006 Interim Meeting) or House of Delegates regarding their implementation. (Res. 422, A-06)

D-30.000 Alcohol and Alcoholism
(See also: Accident Prevention: Motor Vehicles; Drug Abuse; Pregnancy)

D-30.993 A Call for Framework Convention on Alcohol Control

Our AMA (1) will work with other medical and specialty societies to call upon the World Health Organization to draft a binding international treaty, such as a Framework Convention on Alcohol Control (FCAC); and (2) requests that member societies seek individually and collectively to increase support for the development of an FCAC. (Res. 415, A-07)

D-30.994 Take Action to End Alcohol Ads on College Sports Telecasts

Our AMA will enhance its efforts to end alcohol advertising on sports broadcasts and particularly on college sports broadcasts; and to reach this goal, work with others to place special emphasis on college athletic conferences that are now or soon will be negotiating broadcast rights contracts, taking steps that include, but are not limited to:
(1) Appealing directly to the NCAA, all college athletic conferences and member schools to end alcohol ads on their broadcasts;
(2) Encouraging physicians, particularly those in or associated with college communities, to express their opposition to alcohol ads directly to top college administrators;
(3) Urging state and local medical associations to contact colleges in their jurisdictions--particularly in the above conferences--and press them to end alcohol ads on their broadcasts;
(4) Urging state and local medical associations to call on state legislatures to pass resolutions requesting colleges in their state to end alcohol ads on their broadcasts; and
(5) Organizing a "sign-on" letter from medical societies to the NCAA President and Executive Committee urging an end to alcohol ads on NCAA broadcasts. (Res. 413, A-06)

D-30.995 Increasing Taxes on Alcoholic Beverages

Our AMA will:

(1) support increases in federal taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the prevention of alcohol abuse and drunk driving, treatment of persons with alcohol dependence or at-risk drinking patterns, and public health and medical programs that serve vulnerable populations;

(2) encourage state and local medical societies to support increases in state and local taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the purposes noted above;

(3) support, to the extent possible, state and local efforts to increase taxes on beer, wine, and liquor;

(4) collaborate with other national organizations with an interest in this subject, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, Mothers Against Drunk Driving, and the AMA Alliance; and

(5) when state legislative efforts to increase alcohol taxes are stymied, encourage state medical societies to give consideration to the use of ballot initiatives in the 24 states that allow such initiatives. (Res. 438, A-05)

D-30.996 Uniform Drinking Age Standards

Our AMA will encourage Guam's 28th legislature and the Governor of Guam to support 21 as the legal drinking age, support 0.04 percent blood-alcohol level as *per se* illegal for driving, and urge incorporation of that provision in drunk driving laws in all US states and territories in accordance with AMA Policies H-30.986 and H-30.989. (Res. 404, A-05)

D-30.997 Eliminate Underage Alcohol Consumption

Our AMA will: (1) actively oppose underage drinking by working toward a comprehensive community-based environmental approach that includes local and state policies and medical services; (2) support evidence-based public health/environmental policies to curtail destructive and high-risk drinking; and (3) encourage members of all medical and specialty societies to participate on the AMA Action Team on Alcohol and Health. (Res. 442, A-05)

D-30.998 Prevention of Repeat Driving Under the Influence (DUI) Offenses: The Issues of Diversion and Treatment and Vehicle Incapacitation

Our AMA encourages: (1) physicians and their state medical societies to work to create statutes that are designed to treat patients, protect the community and families, and grant immunity to physicians for good faith reporting of drug or alcohol impaired drivers for both permitted or mandated reporting; and (2) further research into and professional discussion about the issues of reporting medical information that could result in punishment or criminal prosecution. (BOT Rep. 17, A-01)

D-30.999 Medicare Coverage for GGTP Assays as Part of Alcoholism Screening

Our AMA will remind physicians of the pervasiveness of alcohol abuse and reemphasize the benefits of early detection of alcoholism in general medical populations, using measures such as a careful clinical history or standardized screening questionnaires. The use of gamma glutamyl transferase in the plasma and mean corpuscular volume assays also may be considered in certain populations. (CMS Rep. 10, A-99)

D-35.000 Allied Health Professions
(See also: Health Manpower; Mental Health; Nursing)

D-35.989 Midwifery Scope of Practice and Licensure

Our AMA will:
(1) only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives;
(2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards;
(3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and
(4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives. (Res. 204, A-08)

D-35.990 Limiting the Scope of Practice of Specialist Assistants in Radiology

Our AMA supports the efforts of the American College of Radiology and will work with the Scope of Practice Partnership and interested Federation partners to obtain regulation or legislation which would preclude a Specialist Assistant in Radiology or other non-physician practitioner from rendering an official report of any image produced by any diagnostic imaging technique. (Res. 219, A-06)

D-35.991 Licensure of Naturopaths

Our AMA will work through the Scope of Practice Partnership and interested Federation partners to oppose the licensure of naturopaths and report back to the House of Delegates at the 2006 Interim Meeting. (Res. 209, A-06)

D-35.992 Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation

Our AMA will: (1) work jointly with state attorneys general to identify and prosecute those individuals who misrepresent themselves as physicians to their patients and mislead program applicants as to their future scope of practice; (2) pursue all other appropriate legislative, regulatory and legal actions through the Scope of Practice Partnership, as well as actions within hospital staff organizations, to counter misrepresentation by nurse doctoral programs and their students and graduates, particularly in clinical settings; and (3) work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified either verbally, or by name badge or similar identifier, with regard to their professional licensure in order that patients are aware of the professional educational background of that person. (Res. 211, A-06)

D-35.993 Limited Licensure Health Care Provider Training and Certification Standards

Our AMA, along with the Scope of Practice Partnership and interested Federation partners, will study the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes, and peer review of the limited licensure health care providers and limited independent practitioners, as identified by the Scope of Practice Partnership, and report back at the 2006 Annual Meeting. (Res. 814, I-05)

D-35.994 Scope of Practice Participants in Health Plans

Our AMA Advocacy Resource Center will work at the invitation of AMA component societies to oppose legislative mandates on health care plans that may lead to inappropriate scope of practice expansion of non-physician providers. (Res. 923, I-04)

D-35.995 Naturopathic Practitioners on Medicare Coverage Advisory Committee

Our AMA will oppose the appointment of naturopathic practitioners to the Medicare Coverage Advisory Committee. (Res. 117, A-04)

D-35.996 Scope of Practice Model Legislation

Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners' scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners' scope of practice. (Res. 923, I-03)

D-35.997 Nonphysician Scope of Practice

Our American Medical Association prepare a compendium of AMA policies on non-physician health professional scope of practice legislative and regulatory initiatives for distribution to the Federation of State Medical Boards no later than the 2003 FSMB meeting, and also to state medical societies who are urged to distribute the compendium to state legislative committees with jurisdiction over scope of practice issues, state governors, state attorneys general and state medical boards (Res. 817, I-02)

D-35.998 New Mexico Psychologist Prescribing Law

Our AMA: (1) in concert with the New Mexico Medical Society and American Psychiatric Association (APA) shall review the circumstances which led to the passage of the clinical psychologist prescribing bill in New Mexico, with the aim of providing the best possible assistance to other states facing similar circumstances; and (2) shall work with the APA to analyze the implications of the clinical psychologist prescribing bill passed in New Mexico on similar initiatives in other states. (Sub. Res. 203, A-02)

D-35.999 Non Physicians' Expanded Scope of Practice (Laboratory Testing and Test Interpretation)

Our AMA, through appropriate legislative and regulatory efforts, seeks to: (1) ensure that diagnostic laboratory testing should only be performed by those individuals who possess appropriate clinical education and training, under the supervision of licensed physicians (MD/DO); and (2) limit laboratory test ordering and interpretation of test results solely to licensed physicians (MD/DO) and licensed dentists (DDS/DMD). (Sub. Res. 307, A-00)

D-40.000 Armed Forces
(See also: Veterans - Medical Care; War)

D-40.991 Acceptance of TRICARE Health Insurance

Our AMA:

1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution.

2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program.

3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services.

4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians.

5. Strongly urges the Tricare Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so

that payments for vaccines reflect the published CDC retail list price for vaccines. (CMS Rep. 2, I-08)

D-40.992 Acceptance of TRICARE Health Insurance

Our AMA will: (1) convene a meeting with representatives of TRICARE to discuss how to improve its contracting process and funding, in order to better the health care of veterans and their families; and (2) report back at the 2008 Interim Meeting on issues regarding TRICARE in light of the increased numbers of new veterans and their families. (Sub. Res. 714, I-07)

D-40.993 Inequity in Military Pay for Physicians

Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a bill based on H.R. 5353 (107th Congress) in this Congress. (BOT Action in response to referred for decision Res. 901, I-03)

D-40.994 Financial Security for Reserve Medical Officers in the US Military

The AMA will: (1) request that the Defense Department conduct a study to determine the shortfall of physicians in reserve components and scope of disincentives and incentives for physicians serving in the military reserves by the Defense Department; (2) ask the military Surgeons General in the House of Delegates to join in this request; and (3) explore the feasibility of suspending dues for current AMA military members who are called to service in Iraq. (BOT Action in response to referred for decision Res. 910, I-02)

D-40.995 The Implications of Health Care Personnel Delivery System

Our AMA will continue to monitor the Health Care Personnel Delivery System (HCPDS) and initiate communication with the Selective Service System and other relevant governmental bodies to address questions and concerns related to the implementation of the HCPDS. (CME Rep. 2, I-04)

D-40.996 Examining the Implications of the Health Care Personnel Delivery System

Our AMA will study the Health Care Personnel Delivery System and its implications for physicians and other health care professionals as well as the civilian health care system and report its findings with any recommendations for change. (Res. 703, I-03)

D-40.997 TRICARE Contract and Billing Issues

Our AMA will: (1) communicate to its members information regarding recent TRICARE program expansions, as well as related information to assist physicians in TRICARE contracting decisions; (2) inform its members that TRICARE Managed Care Support contractors have the authority to increase Maximum Allowable Charges (MACs) in effect under this program, and to negotiate payments above such charges with individual physicians in order to recruit or retain adequate supplies of physicians for their networks; and (3) elicit information from civilian physicians who have unfairly incurred the costs of treating TRICARE beneficiaries without a right to balance bill and, based on analysis of the collected complaints, consider legally appropriate regulatory, legislative, and/or judicial remedies. (CMS Rep. 1, I-01)

D-40.998 Champus/Tricare Contracting and Billing Issues

Our AMA will: (1) study and seek solutions to the problems with the Champus/Tricare program that have resulted in low numbers of physicians voluntarily entering into contract with that program; and (2) study the problems associated with the inability of physicians who do not have contracts with the Champus/Tricare program to bill outside the Champus/Tricare program for beneficiaries of that program and seek legislative or judicial remedies for those problems. (Res. 114, A-01)

D-40.999 Medical Care for Persian Gulf War Veterans

Our CSA and COL will continue to monitor developments in the identification of possible Gulf War illnesses and Congressional initiatives related to the health care of those who served in the Persian Gulf during the early 1990s, and respond as appropriate. (BOT Rep. 9, A-00)

D-45.000 Aviation Medicine

D-45.996 Air Travel for Patients Using Supplemental Oxygen

Our AMA will formally submit comments encouraging the Department of Transportation's Proposed Rule that will require airlines to permit portable oxygen concentrators that have met all applicable safety and security testing on board airplanes for use by patients. (Res. 719, I-05)

D-45.997 Commercial Aircraft Water Quality and Safety

Our AMA will: (1) recognize the efforts of the US Environmental Protection Agency (EPA) and participating commercial airlines to improve water sanitation on domestic passenger aircraft; and (2) support the current efforts by the EPA to amend the regulatory authority of the US Department of Transportation to include water system sanitation and sanitation testing as part of routine passenger aircraft maintenance as mandated under 14 CFR Part 121, 14 CFR Part 135, and other appropriate Federal Aviation Regulations, and to submit formal comments to the Proposed Rule for this amendment to the regulations. (Res. 711, I-05)

D-45.998 Reducing the Risk of Flight-Associated Venous Thrombosis

Our AMA will continue to monitor research on developments concerning the relationship between air travel and venous thromboembolism and respond appropriately when more definitive results become available. (CSA Rep. 4, A-04)

D-50.000 Blood
(See also: Acquired Immunodeficiency Syndrome)

D-50.998 Blood Donor Recruitment

Our AMA shall encourage the Food and Drug Administration to continue evaluating and monitoring regulations on blood donation and to consider modifications to the current exclusion policies if sufficient scientific evidence supports such changes. (Sub. Res. 401, A-02)

D-50.999 Blood Transfusion Reimbursement Issues Addressed by CMS

Our AMA will join the American Hospital Association, the American Association of Blood Banks, the American Red Cross, and America's Blood Centers in urging the CMS to assure adequate reimbursement for blood services as a way to reduce barriers to needed care. (Res. 115, I-00)

D-55.000 Cancer

D-55.997 Cancer and Health Care Disparities Among Minority Women

Our AMA: (1) encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment; and (2) will work with the National Cancer Institute's Center to Reduce Cancer Health Disparities, the American Cancer Society, and other organizations to promote the use among minority women of educational materials that are culturally sensitive and at the appropriate literacy level. (Res. 509, A-08)

D-55.998 Encourage Appropriate Colorectal Cancer Screening

Our AMA, in conjunction with interested organizations and societies, will promote educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high risk groups, including all individuals over age 50. (Res. 510, A-03)

D-60.000 Children and Youth
(See also: Contraception; Health Education; Infant Health; Pregnancy; Sports and Physical Fitness)

D-60.971 Reduction of Underage Drinking

Our AMA supports the goals and strategies included in "The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking" and will work toward the goal of reducing underage drinking. (Res. 424, A-08)

D-60.972 Internet Marketing to Children on Health

Our AMA: (1) supports the use of the Internet for educating children about healthy habits and lifestyles; and (2) will seek opportunities to partner with other organizations to study and promote Internet marketing strategies to educate children across the United States about healthy habits and lifestyles. (Res. 410, A-08)

D-60.973 Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths

1. Our AMA will advocate for a ban on the marketing of products such as alcopops, gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks

that have special appeal to youths under the age of 21 years of age.

2. Our AMA supports state and federal regulations that would reclassify Alcopops as a distilled spirit so that it can be taxed at a higher reate and connot be advertised or sold in certain locations. (Res. 435, A-07; BOT Action in response to referred for decision Res. 411, A-08)

D-60.974 Emotional and Behavioral Effects of Video Game and Internet Overuse

Our AMA:

(1) urges agencies such as the Federal Trade Commission as well as national parent and public interest organizations such as the Entertainment Software Rating Board, and parent-teacher organizations to review the current ratings system for accuracy and appropriateness relative to content, and establish an improved ratings systems based on a combined effort from the entertainment industry and peer review;

(2) will work with key stakeholder organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians to (a) educate physicians on the public health risks of media exposure and how to assess media usage in their pediatric populations and (b) provide families with educational materials on the appropriate use of video games;

(3) supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger;

(4) encourages organizations such as the Centers for Disease Control and Prevention, the National Science Foundation, and the National Institutes of Health to fund quality research (a) on the long-term beneficial and detrimental effects not only of video games, but use of the Internet by children under 18 years of age; and (b) for the determination of a scientifically-based guideline for total daily or weekly screen time, as appropriate; and

(5) will forward Council on Science and Public Health Report 12-A-07, Emotional and Behavioral Effects of Video Game and Internet Overuse, to the American Psychiatric Association and other appropriate medical specialty societies for review and consideration in conjunction with the upcoming revision of the *Diagnostic and Statistical Manual of Mental Disorders*. (CSAPH Rep. 12, A-07)

D-60.975 Early Literacy Programs

Our AMA encourages physicians to participate in early literacy programs to promote literacy development, educate parents on child development, and strengthen family interactions, so that these programs become a common part of child health care as a foundation for school readiness. (Res. 423, A-07)

D-60.976 Childhood Anaphylactic Reactions

Our AMA will:

(1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy and Anaphylaxis Network; and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment;

(2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis;

(3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis;

(4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies;

(5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and

(6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis. (CSAPH Rep. 1, A-07)

D-60.977 Exclusion of Homeless Children from Deficit Reduction Act Documentation Requirements

Our AMA will advocate for exclusion of homeless infants, children, adolescents, and young adults from the requirements of the Deficit Reduction Act that they document their citizenship and identification under Section 6036 of the Deficit Reduction Act of 2006, "Improved Enforcement of Documentation Requirements." (Res. 120, A-07)

D-60.978 Resources to Combat Teen and Young Adult Suicide in the United States

Our AMA will convene a time-limited work group to meet through conference call to identify and evaluate appropriate resources for physicians intended to prevent and reduce teen and young adult suicide, and that such resources be maintained on a publicly accessible Web page hosted by our AMA. (CSAPH Rep. 3, I-06)

D-60.979 Childhood Anaphylactic Reactions

Our AMA will:
(1) summarize the most recent scientific literature pertaining to the increased incidence of anaphylactic reactions in children;
(2) develop specific strategies aimed at reducing the incidence of anaphylactic reactions among children; and
(3) support legislative efforts to ensure that children have appropriate access to necessary medical interventions for the treatment of asthma and acute anaphylactic reactions in school settings. (Res. 518, A-06)

D-60.980 Emergency Medical Services for Children (EMSC) Program

Our AMA will: (1) reaffirm the importance of Emergency Medical Services for Children (EMSC); (2) advocate for full funding for the EMSC program in Congress; and (3) advocate for passage of EMSC reauthorization legislation in Congress. (Res. 213, A-06)

D-60.981 The Diagnosis and Treatment of ADHD

Our AMA Council on Science and Public Health will work with all appropriate specialty societies to prepare an update to the 1997 CSA report on the diagnosis and treatment of Attention Deficit Hyperactivity Disorder. (Res. 410, A-06)

D-60.982 Long Term Effects of Early Abuse/Neglect on Brain Development

Our AMA will:

(1) work with national organizations, e.g., American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American College of Obstetricians and Gynecologists, and others involved with early brain research, child abuse and neglect and public education to make educational materials available to hospital infant and pediatric personnel, physicians, parents, other child care providers and educators and the public at large;

(2) urge state and local medical societies to work with their legislators to put in place educational, and where appropriate, support programs for those involved with infants and young children, i.e., parents, students in junior and senior high school, child care providers, and early childhood educators; and

(3) work with the federal government and pertinent agencies to make this issue--prevention of early abuse and brain damage with its devastating long term effects for individuals and society--a priority of our nation. (BOT Action in response to referred for decision Res. 526, A-02)

D-60.983 Teen and Young Adult Suicide in the United States

Our AMA will work with appropriate federal agencies, national organizations, and medical specialty societies to compile resources to reduce teen and young-adult suicide, including but not limited to continuing medical education classes, patient education programs, and other appropriate educational and interventional programs for health care providers, and report back at the 2006 Interim Meeting. (Res. 424, A-05)

D-60.984 School-Based and School-Linked Health Centers

Our AMA will: (1) firmly support the concept of adequately equipped and staffed School-Based or School-Linked Health Centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence; and (2) endeavor to work with state and federal agencies and departments, private donors, industry and corporate entities, and other interested parties in the creation, funding and sustaining of SBHCs throughout the country. (Res. 412, A-05)

D-60.985 Children and SSRI Antidepressants

Our AMA Council on Scientific Affairs will work in conjunction with all appropriate specialty societies to prepare an independent, comprehensive review of the scientific data currently available pertaining to the safety and efficacy of the use of Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants in the treatment of child and adolescent psychiatric disorders. (Res. 803, I-04)

D-60.986 Access to Asthma Medication at School

Our AMA will urge the states that have not yet adopted legislation ensuring the right of children to carry and self-administer asthma metered-dose inhalers to pass such legislation. (Sub. Res. 912, I-04)

D-60.987 Gender-Specific Rehabilitation Programs, Mental Health and Educational Services for Girls in the Juvenile Detention System

Our AMA will work with appropriate organizations to evaluate gender-specific rehabilitation programs, mental health services and educational services in juvenile detention centers, and community-based programs for delinquent girls who have been adjudicated. (Res. 411, A-03)

D-60.988 Early Childhood and Family Education as a Mechanism to Advance Family Health

Our AMA will advocate for the continuation and expansion of early childhood family education programs nationwide. (Res. 426, A-03)

D-60.989 Effects of Alcohol on the Brains of Underage Drinkers

Our AMA will consult with relevant specialty societies (whose members provide care for adolescents and young adults) in order to create a higher level of awareness about the harmful consequences of underage drinking, and seek to work collaboratively to address the underage drinking problem (CSA Rep. 11, A-03)

D-60.990 Exercise and Healthy Eating for Children

Our AMA shall: (1) seek legislation that would require the development and implementation of evidence-based nutrition standards for all food served in K-12 schools irrespective of food vendor or provider; and (2) work with the US Public Health Service and other federal agencies, the Federation, and others in a coordinated campaign to educate the public on the epidemic of childhood obesity and enhance the K-12 curriculum by addressing the benefits of exercise, physical fitness, and healthful diets for children. (Res. 423, A-02; Reaffirmation A-04; Reaffirmation A-07; Reaffirmation I-07)

D-60.991 Childhood Asthma: Emerging Patterns and Prospects for Novel Therapies

Our AMA shall: (1) encourage the Centers for Disease Control and Prevention; the American Lung Association; the National Heart, Lung, and Blood Institute; the American Academy of Pediatrics; the American Academy of Family Physicians; and others to work together to develop a comprehensive and uniform definition of childhood asthma;

(2) educate physicians using existing communication channels on the problem of childhood asthma in the United States, including basic epidemiologic patterns underlying much of the recent interest in the environmental and demographic disparities in the prevalence of childhood asthma;

(3) encourage the National Center for Health Statistics, the American Lung Association, and others to develop better data on the incidence and prevalence of childhood asthma morbidity and mortality, including complete demographic, environmental, and socioeconomic information;

(4) encourage physicians to make use of guidelines for the treatment of childhood asthma, including those contained in Expert Panel Report II: Guidelines for the Diagnosis and Management of Asthma, released by the National Heart, Lung, and Blood Institute, and the Promoting Best Practice Guide for Management of Asthma in Children, released by the American Academy of Allergy, Asthma and Immunology; and

(5) shall continue to support the efforts of the Physician Consortium for Performance Improvement (The Consortium) to develop evidence-based performance measures for asthma care. Furthermore, that our AMA encourage The Consortium to explore the feasibility of performance measures for asthma care of children less than 5 years of age. (CSA Rep. 2, A-02)

D-60.992 Bullying Behaviors Among Children and Adolescents

Our AMA shall work with appropriate federal agencies, medical societies, the Alliance, mental health organizations, education organizations, schools, youth organizations, and others in a national campaign to change societal attitudes toward and tolerance of bullying, and advocate for multifaceted age and developmentally appropriate interventions to address bullying in all its forms. (CSA Rep. 1, A-02)

D-60.993 Bullying Behavior Among Youth

Our AMA: (1) will address bullying as a major component of its violence prevention program;

(2) will encourage appropriate public and private funding agencies to support research on bullying behavior and anti-bullying interventions (e.g., through special Requests for Proposals;

(3) through the Council on Scientific Affairs, will review the available research on the efficacy of intervention programs designed to reduce bullying;

(4) will work with specialty societies, state and local medical associations, the Alliance, public health agencies, departments of education, and other interested parties in preparing and disseminating materials that will help schools, teachers, parents, and others to address bullying at the local level; and

(5) will evaluate survey instruments that can be used to measure the incidence of bullying. (Res. 413, A-01)

D-60.994 Sexually Transmitted Diseases Among Adolescents, Including Incarcerated Juveniles

Our AMA will increase its efforts to work in conjunction with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted diseases and sexual abuse. (Res. 401, A-01)

D-60.995 Use Of Psychotropic Drugs In Children

Our AMA will work in conjunction with the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and other relevant organizations, to encourage more research into the safety and efficacy of psychotropic medications in children, especially those under 4 years of age. (Res. 504, I-00)

D-60.996 Safe Place for Newborns

Our AMA will study and draft model state legislation to protect women from prosecution who surrender or abandon their infants safely to a health care facility, law enforcement or other appropriate entity. (Res. 241, A-00)

D-60.997 Neonatal Circumcision

CSA Report 10, "Neonatal Circumcision" be published, and posted on the CSA web page, with links to sites that provide fact sheets on circumcision for consumers and physicians that are in accord with the findings of Recommendation 2.

Recommendation 2: Our AMA supports the general principles of the 1999 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows:

"Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In circumstances in which there are potential benefits and risks, yet the procedure is not essential to the child's current well-being, parents should determine what is in the best interest of the child. To make an informed choice, parents of all male infants should be given accurate and unbiased information and be provided the opportunity to discuss this decision. If a decision for circumcision is made, procedural analgesia should be provided." (CSA Rep. 10, I-99)

D-60.998 Seclusion and Restraint of Children and Adolescents

Our AMA will: (1) encourage and support the development and use of guidelines on the use of seclusion and restraint with children and adolescents by appropriate medical specialty groups, including the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics and the American Psychiatric Association; (2) encourage empirical studies of the effects of seclusion and restraint on child and adolescent patients in all settings; and (3) monitor the development and implementation of standards, rules, or guidelines on the use of seclusion and restraint, particularly as they may apply to children and adolescents, with reports back as necessary. (CSA Rep. 10, A-99)

D-65.000 Civil and Human Rights
(See also: Minorities; Women)

D-65.994 Physician Participation in the Interrogation of Prisoners and Detainees

Our American Medical Association Council on Ethical and Judicial Affairs, with input from all appropriate AMA stakeholders, will delineate clearly for physicians the boundaries of ethical practice with respect to participation in the interrogation of prisoners and detainees. (Res. 1, I-05)

D-65.995 Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families

Our AMA will work to reduce the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children. (Res. 445, A-05)

D-65.996 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

Our AMA will encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity." (Res. 414, A-04; Modified: BOT Rep. 11, A-07)

D-65.997 Humane Treatment of Prisoners and Detainees

Our AMA endorses ongoing formal review of US interrogation practices of prisoners and detainees. (Sub. Res. 12, A-04)

D-65.998 Elimination of Discrimination of Women

Our Board of Trustees believes that existing AMA policy addresses the need for equitable treatment of men and women, and recommends an examination of AMA policy to the extent that gaps exist in this area. (BOT Rep. 21, I-01; Reaffirmation A-05)

D-65.999 Nondiscrimination in Responding to Terrorism

Our AMA will: (1) reaffirm its commitment to work with appropriate agencies and associations in responding to terrorist attacks; and (2) publicize this position, widely indicating that the nation's response to terrorism must not involve discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of medical education or health care training (Res. 1. I-01)

D-70.000 Coding and Nonmenclature
(See also: Health Insurance; Health Insurance: Benefits and Coverage; Health Insurance: Claim Forms and Claims Processing; Medicare; Physician Payment; Physician Payment: Medicare; Physician Fees)

D-70.955 Postoperative Care of Surgical Patients

1. Our AMA (a) continues to strongly encourage the Centers for Medicare and Medicaid Services and private payers to recognize CPT codes, and follow guidelines and conventions as they relate to appending appropriate CPT modifiers 54, 55, and 56 to describe the segment of preoperative, surgical or postoperative care performed during the global period of a procedure when more than one physician delivers a specific segment of the care; and (b) will continue to educate physicians and their billing staff on how to appropriately use CPT codes, guidelines, and conventions when another physician provides services during the postoperative period.

2. The CPT Editorial Panel and the AMA/Specialty Society Resource Based RVS Update Committee will be encouraged to work with interested medical specialties to further address issues related to physician payment for the provision of postoperative care.

3. Our AMA reaffirms and will publicize policy D-70.955, which encourages private payers to recognize CPT codes and follow guidelines and conventions as they relate to appending appropriate CPT modifiers 54, 55, and 56 to describe the segment of pre-operative, surgical, or post-operative care performed during the global period of a procedure when more than one physician delivers a specific segment of the care. (BOT Action in response to referred for decision CMS Rep. 3, I-06; Reaffirmed and Modified: CMS Rep. 1, A-08)

D-70.956 Development of a Drug Classification Advisory Panel to Facilitate Appropriate Use of CPT Drug Administration Codes

Our AMA will:
(1) ask the CPT Editorial Panel to consider revisions to the existing drug administration codes to add enhanced section and subsection headings, guidelines and parenthetic references, with the intention of assisting users in the application of the codes;
(2) develop educational material to assist users in the application of CPT drug administration codes; and
(3) continue to monitor the issue of drug classification within CPT drug administration code categories for physician billing and claims problems. (BOT Rep. 10, A-07)

D-70.957 Fixed Reimbursement to Physicians for Laboratory Services

Our AMA: (1) encourages physicians to become knowledgeable about the appropriate use of CPT modifier 26 in order to bill the professional component separately from the technical component for the interpretation of laboratory tests and clinical oversight of the laboratory; and (2) will advocate that Medicare and other third party payers provide appropriate coverage for the use of CPT modifier 26, as well as care plan oversight codes and prolonged services codes. (CMS Rep. 2, I-06)

D-70.958 Blended Payments

Our AMA will work with Congress to make it illegal for insurance companies to unilaterally change payments by "blending" levels. (Res. 809, I-06)

D-70.959 CPT Modifiers

1. Our AMA will explore developing an editorial process for publication of CPT Assistant. Any such process should be designed to facilitate input from public and private payers, physician organizations, non-physician health care professional organizations, and other CPT stakeholders. The development of an editorial process for CPT Assistant must also consider the deadlines inherent in a monthly newsletter and a timely process for resolving conflict among editorial advisors.

2. Our AMA, beginning in June 2006, encourages that attendance at CPT Editorial Panel meetings be open to all CPT stakeholders including: public and private health care payers; the device, pharmaceutical and laboratory industries; CPT licensees and software vendors; and coding consultants. Existing distribution restrictions and confidentiality provisions regarding CPT code change proposals and agenda material will continue to exist so as not to conflict with code effective dates or disrupt the CPT Editorial Panel's process. All participants will be made aware of confidentiality restrictions and attendees outside of CPT Advisors and staff will be required to sign confidentiality agreements.

3. Our AMA will explore establishing a committee and process for the periodic review and analysis of code editing packages, both public and private, for compliance with CPT coding rules and guidelines. Such a process must have the assured participation and approval of two-thirds of the CPT/HCPAC Advisory Committee, with at least eight to twelve CPT/HCPAC Advisors agreeing to serve as committee members on a rotating basis. Such a process must also have the cooperation of code edit vendors, for availability of edit products, and must not be unduly restricted by nondisclosure agreements. Results of the committee's analysis will be conveyed only to the specific vendor whose product was reviewed.

4. A CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure, unless CPT coding guidelines specifically direct users not to report the service or procedure (i.e., separate procedure codes), and that if the service or procedure is reimbursed zero dollars, or otherwise not recognized by an insurer, the service or procedure should be considered uncovered and thus billable to the patient. (BOT Action in response to referred for decision Res. 828, I-05)

D-70.960 Implementation of ICD-10-CM

Our AMA will work for delayed implementation of a simplified, modified ICD-10-CM coding system which is less burdensome on practicing physicians, hospitals, and the health insurance industry. (Res. 719, A-06)

D-70.961 CMS New Definition of Consultation

Our AMA will review the new definitions as proposed by the Centers for Medicare and Medicaid Services in its transmittals 782 and 788 of what constitutes a consultation and recommend appropriate changes to CMS, if necessary. (Res. 717, A-06)

D-70.962 Palliative Care and End-of-Life Care

Our AMA:
1. Encourages all physicians to become skilled in palliative medicine techniques and to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services.
2. Advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside

of the face-to-face encounter in non-hospital settings. (BOT Rep. 5, A-06)

D-70.963 Pilot Studies of E&M Clinical Examples and Peer Review of Outliers

Our AMA will:

(1) continue to advocate that the Centers for Medicare and Medicaid Services (CMS) conduct pilot studies on the use of clinical examples to guide physicians in determining appropriate Evaluation and Management (E&M) code levels;

(2) in cooperation with state and specialty societies, work to educate physicians and their coding staff on the use of CPT E&M codes including clinically appropriate documentation that supports quality patient care;

(3) work with the CMS Program Integrity Group and the Department of Health and Human Services Office of Inspector General (HHS OIG) to: (a) clarify and simplify the criteria that would trigger an audit under the Medicare program; (b) establish and promulgate the rules, including the rights of physicians, by which such audits would be conducted; (c) develop guidelines for setting penalties, beginning with physician education, for specified levels of audit discrepancies and Medicare billing errors; and (d) disregard one level difference in CPT E&M codes and not consider one level differences an error for audit or error report purposes;

(4) advocate forcefully with CMS and HHS OIG to: (a) eliminate all random review of E&M services now; (b) identify methods to define statistical "outliers"; (c) refer to independent peer reviewers who are actively practicing and of the same specialty as the physician under review those cases statistically defined as outliers; (d) assure that post-payment review of E&M services would also rely on peer review before any adverse actions are taken; and (e) have an appeal process at all levels of review;

(5) seek legislation and/or regulatory change that would require (a) CMS, the HHS OIG and third party carriers, to conduct Medicare and Medicaid audits in a fair manner with recognition that E&M code level assignment is imprecise; and (b) that audits must consider coding patterns in the aggregate, so as to include consideration of both assessments for up-coding as well as credits for downcoding; and

(6) seek legislation and/or regulatory change that would limit CMS, the HHS OIG and third party carriers from using spurious claims of fraud and other excessive tactics which put physicians in seriously compromised positions wherein they cannot obtain fair and just resolution of audit results. (Sub. Res. 819, I-04)

D-70.964 Time Based Codes for Counseling and Education

Our AMA CPT Editorial Panel will develop additional educational materials to assist physicians in applying CPT guidelines for use of E&M codes. (BOT Rep. 11, I-04; Reaffirmed in lieu of Res. 823, I-06)

D-70.965 Membership on RVS Update Committee (RUC) and CPT Coding Committee

Our AMA will request that representative societies send delegates or alternate delegates to the American Medical Association/Specialty Society Relative Value Scale Update Committee and the AMA Current Procedural Terminology Editorial Panel and Physician Advisory Committee who are currently engaged for a substantial portion of their professional activities with the practice of medicine either in active patient care or closely-related activities. (Res. 611, I-04)

D-70.966 Electronic Communication Service Codes

Our AMA CPT Editorial Panel will consider refining the current tracking code for electronic communication into a new code for non-telephone electronic communications, including but not limited to facsimile and e-mail. (Sub. Res. 712, A-04; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-07)

D-70.967 Health and Behavior Assessment/Intervention

Our AMA CPT Editorial Panel will consider refining health and behavioral assessment codes to allow for the development of improved definitions so that appropriate coverage and payment determinations can be made. (Sub. Res. 711, A-04)

D-70.968 National Standard for Code Combinations

Our AMA will study and report back to the House of Delegates on the feasibility of developing a national standard for the utilization of codes, code combination, and modifiers that is consistent with all CPT codes, guidelines, and conventions, and that would be used by all commercial and governmental payers. (Sub. Res. 709, A-04; Reaffirmation I-04)

D-70.969 Discriminatory Payment Polices

Our AMA Private Sector Advocacy group will work to have private insurers pay all E&M codes equitably so that patients with chronic conditions are not limited in their access to care. (Res. 728, A-04; Reaffirmation I-04; Reaffirmation A-08)

D-70.970 Patient and Physician Advocacy in Infusion Therapy

Our AMA will work with interested medical organizations as well as lay support groups as needed, to ensure that infusion supervision codes appropriately reflect the complexity of the infusion service rendered, and that there be sufficient relative value units to such service provided, as well as attendant practice expense, such that patient access to infusion therapies remains uninterrupted. (Res. 729, I-03)

D-70.971 Uses and Abuses of CPT Modifier -25

(1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.

(2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.

(3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.

(4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.

(5) Our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers.

(6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.

(7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.

(8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply. (BOT Rep. 10, I-03)

D-70.972 Online Evaluation Procedure Codes

Our AMA CPT Editorial Panel will explore developing codes for online evaluation services between a physician and an established patient. (Res. 717, A-03; Reaffirmation I-04; Reaffirmation A-05)

D-70.973 Creation of an ICD-10-CM Code for Tissue Hypoxia

Our AMA will explore the creation of an ICD-10-CM code for tissue hypoxia. (Res. 702, A-03)

D-70.974 Reimbursement for Evaluation and Management Visit Performed on the Same Day as a Preventive Visit

Our AMA CPT Editorial Panel will look into other means of reporting this combination of services (E&M visit on the same day as a preventive visit) that are more definitive and clearly identify additional non-duplicative services which warrant separate reimbursement (for example, the add-on codes in the Psychiatric Section of the CPT, codes 90804 through 90829) (Res. 718, A-03; Reaffirmation I-07)

D-70.975 Appropriate Reimbursements and Carve-Outs for Vaccines

Our AMA will continue to advocate for health plan adherence to CPT, including the use of CPT codes that identify the administration of vaccines, as well as the actual vaccine product. (BOT Rep. 20, A-03; Reaffirmation A-07)

D-70.976 Development of Clinical Examples for E&M Services

Our American Medical Association ask the CPT Editorial Panel to proceed with all due haste to complete the process of clinical

example development so that revised Evaluation and Management (E&M) codes can be implemented. Our AMA Board of Trustees shall report back to the House of Delegates on progress made by the 2003 Annual Meeting. (Res. 822, I-02)

D-70.977 Qualified Support for the HHS Advisory Committee on Regulatory Reform's Recommendation to Eliminate the E&M Guidelines

The Board of Trustees Ad Hoc Task Force on E&M Documentation Guidelines shall be extended until A-05. (Res. 818, A-02)

D-70.978 Conscious Sedation Reimbursement

The Workgroup of the AMA/Specialty Society RVS Update Committee (RUC) and the CPT Editorial Panel shall continue to study and resolve the issue of conscious sedation coding. (BOT Rep. 9, A-02)

D-70.979 Preservation of Five Levels of Evaluation and Management Services

Our AMA will: (1) communicate to the Centers for Medicare and Medicaid Services (CMS) and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level; and (2) study the issue of five levels of E&M Coding for the purpose of maintaining a plurality of levels in order to preserve coding flexibility and appropriate payment. (Sub. Res. 804, I-01; Reaffirmation A-06; Reaffirmed in lieu of Res. 823, I-06)

D-70.980 CPT Editorial Panel Representation

Our AMA Board of Trustees will study, document and report on the mechanisms for choosing CPT Editorial Panel participants and delineate the process for including physicians who care for special populations on the Panel. (Sub. Res. 803, I-01)

D-70.981 CPT Tracking Code for EMTALA-Related Services

Our AMA: (1) will urge the CPT Editorial Panel to create a CPT tracking code(s) to be used by physicians to identify EMTALA-related services; and (2) in conjunction with state and specialty societies, educate physicians about this code(s) and encourage physicians to utilize the appropriate code(s) to aid in the collection of EMTALA uncompensated care data. (Res. 814, I-01)

D-70.982 Fair Payment for Separate Services

(1) Our AMA will: (1) continue to oppose the inappropriate bundling practices of insurance carriers through the incorrect use of CPT codes;

(2) take appropriate action to encourage that all third party payers accept, utilize and reimburse physicians based on the most current version of CPT codes and modifiers and that inappropriate bundling of such codes be prohibited;

(3) support legislative measures that will enforce the correct coding concept, that if two or more medically necessary services are payable when provided on different dates, they must not be less payable when provided on the same date; and

(4) report back at I-02 (Res. 705, I-01; Reaffirmation A-05; Reaffirmation I-07)

D-70.983 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices;

(2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment;

(3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate;

(4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician;

(5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by

their state legislatures; and.

(6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue. (CMS Rep. 6, I-01)

D-70.984 Medicare Preoperative Medical Evaluation

Our AMA will: (1) express support for the policy on preoperative medical evaluations prepared by Centers for Medicare and Medicaid Services;

(2) continue working with interested specialty societies to address specific aspects of the policy that may need further clarification;

(3) monitor the effects of the new policy on payment of claims for preoperative examinations and diagnostic tests;

(4) continue to work with the Centers for Medicare and Medicaid Services' Physicians' Regulatory Initiative Team to ensure that the problem of carrier denials of claims for preoperative evaluation is satisfactorily resolved; and

(5) distribute to national medical specialty societies this report and invite them to participate in the process, including developing recommendations on evidence-based preoperative testing. (BOT Rep. 6, A-01)

D-70.985 Correct Coding Initiative/Mandatory Use of Modifier-25

Our AMA will strongly object to CMS's mandate that CPT modifier-25 be used for E&M services performed on the same date as many diagnostic services and further advocate that (a) these correct coding initiative (CCI) edits be immediately eliminated; (b) Medicare carriers reprocess all denied claims; and (c) CMS should not make similar changes in the future without adequate public notice and comment and the notification of providers. (Sub. Res. 825, I-00)

D-70.986 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will study the problems associated with inappropriate bundling of medical services, including the bundling of preoperative assessment in making the decision for surgery with the procedure, and present a report with potential solutions, including an analysis of legislative, judicial, and regulatory remedies. (Res. 813, I-00)

D-70.987 Appropriate Use of Component Codes in Current Procedural Terminology (CPT)

(1) Our AMA will pursue methods of wide distribution for existing coding products and services developed by national specialty societies in cooperation with the AMA and the CPT Editorial Panel. (2) Our AMA will advocate that the Department of Health and Human Services (DHHS) designate CPT guidelines and instructions as contained in the CPT Book and approved by the CPT Editorial Panel as the national implementation standards for CPT codes. (3) The CPT Editorial Panel consider developing CPT coding combinations that comply with CPT coding rules and guidelines and that could serve as a basis for payer software programs. (BOT Rep. 8, I-00)

D-70.988 Bundling Physicians Claims

(1) Our AMA will take immediate action to discuss and implement H-70.937, H-70.949, H-70.962, H-70.980, H-70.985, and H-285.946, to bring an end to the unilateral and unfair reimbursement methods being used by carriers and insurance companies in their efforts to reduce reimbursement. (2) If discussions with the carriers and insurance companies on the immediate implementation of AMA Policies H-70.937, H-70.949, H-70.962, H-70.980, H-70.985, and H-285.946 fail to bring a satisfactory response, the AMA Board of Trustees seek all possible legal avenues for implementation of the items called for in these policies. (Res. 814, A-00)

D-70.989 Support for Component Coding

Our AMA will aggressively pursue the appropriate use of coding through development of educational materials on component coding with a report back to the House for I-00. (Sub. Res. 816, A-00)

D-70.990 E&M Guidelines and Ad Hoc Task Force

The Ad Hoc Task Force on E&M Guidelines continue its present function, including its advisory position to the AMA Board of Trustees, until A-2001. (Sub. Res. 803, A-00)

D-70.991 Insurers Excessive Documentation Requirements and Claims Submission

Our AMA will: (1) communicate with insurers that requires submission of medical record documentation for all Level 4 or Level 5 E & M codes that this practice is unacceptable and should be rescinded immediately; and (2) seek, if necessary, legal and governmental intervention to prevent any organization from requiring automatic and mandatory submission of medical record documentation for all CPT codes except unlisted procedures and codes with modifier-22. (Res. 827, A-00)

D-70.992 Denial of Claims when Multiple or Bilateral Procedures are Performed

Our AMA will: (1 engage itself in a very aggressive way to set realistic standardized methods of coding and reimbursement when multiple or bilateral procedures and or interventions are performed on a single date, which will result in being able to submit clean claims for prompt payment; (2) engage in discussion with all major health insurance companies and Medicare carriers on adopting realistic standardized methods of coding and reimbursement when multiple or bilateral procedures and or interventions are performed on a single date; and (3) report back at the 2000 Interim Meeting. (Res. 815, A-00)

D-70.993 Reimbursement for Telephonic and Electronic Communications

Our AMA will request proposals to the CPT Editorial Panel to create better reporting extensions of face-to-face physician work, recognizing a wide range of communications including telephone consultation, fax, e-mail, video or other evolving communication forms. (Res. 810, A-00)

D-70.994 Additional ICD Codes for Diabetes Related Conditions

Our AMA ask the National Center for Health Statistics to develop ICD codes for these diabetes related conditions: Impaired Fasting Glucose, Impaired Glucose Homeostasis, and Impaired Glucose Tolerance. (Res. 807, A-00)

D-70.995 Use of "Encounter Time" for Evaluation and Management Services

(1) Our AMA will study the concept that would allow documentation of "encounter time" as a further indication of physician "work" for evaluation and management services; and (2) A progress report from the BOT on the analysis of this issue be provided to the HOD at the 2000 Annual Meeting. (Sub. Res. 824, A-99)

D-70.996 Timely Distribution of Medicare Office Laboratory Fee Schedules

Our AMA will work with CMS to require that all Medicare carriers include the Laboratory Fee Schedule with the Enrollment Package and Physician Fee Schedule for Medicare Part B each year. (Res. 113, A-99)

D-70.997 Negotiated Rulemaking for Lab Tests

Our AMA: (1) reaffirms its policy to seek repeal of Section 4317 of the Balanced Budget Act of 1997 granting the Secretary of HHS authority to require submission of diagnosis codes with every lab test claim and with all claims for services provided by an entity other than the ordering physician; (2) continues to urge CMS to clarify and improve the Advanced Beneficiary Notice process; and (3) will work to modify the regulations forthcoming in the implementation of the Health Insurance Portability and Accountability Act (HIPAA) to conform with AMA policy. (BOT Rep. 11, A-99)

D-70.999 Diagnostic Procedural Coding System

Our AMA will continue: (1) to monitor developments related to ICD-10-PCS and inform AMA members about proposed users and potential costs of the system;

(2) its work on the development of CPT-5, addressing such key issues as the maintenance process, hierarchical code structure, code specificity, and costs of adoption and maintenance, and seek to maintain its leadership position in code development and maintenance;

(3) to explore opportunities to include medical specialty societies and other organizations with expertise in the formulation of clinical terminology in the development of CPT-5; and

(4) inform physicians and other users of CPT about the development of CPT-5 and provide updates on its progress, as they become available. (BOT Rep. 4, I-98; Reaffirmed: CMS Rep. 4, A-08)

D-75.000 Contraception
(See also: Abortion; Pregnancy)

D-75.996 Emergency Contraception for Sexual Assault Victims

Our AMA will urge that the United States Justice Department's new National Protocol for Sexual Assault Medical Forensic Examination be amended to include a full discussion and recommendations on the use of emergency contraception to prevent unwanted pregnancy in sexual assault victims, in line with established recommendations by the American College of Obstetricians and Gynecologists and other relevant medical organizations. (Res. 417, A-05)

D-75.997 Access to Emergency Contraception

1. Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public; and (b) support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA).

2. Our AMA: (a) will work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their web site or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (b) urges that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel. (CMS Rep. 1, A-00; Appended: Res. 506, A-07)

D-75.998 Access to Emergency Contraception

(1) Our AMA will study the issue of access to Emergency Contraception. (2) The study include the issue of after hours access and access in communities served by hospitals and pharmacies that restrict Emergency Contraception from their inventory. (3) Our Board of Trustees will report back to the House of Delegates at the I-00 meeting. (Res. 116, I-99)

D-75.999 Emergency Contraception Pills

Our AMA will support public health education on all forms of contraception, including emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and other organizations to encourage the widespread dissemination of this information. (Res. 403, A-99)

D-80.000 Crime
(See also: Legal Medicine; Prisons; Violence and Abuse)

D-80.999 Availability and Use of All Appropriate Medical Forensic Techniques in the Criminal Justice System

Our AMA will distribute this report nationally to representatives of local, state and federal criminal justice agencies, including prosecutors' and public defenders' offices, in order to furnish information that can be used to enhance the quality and accessibility of DNA evidence in the criminal justice system. (BOT Rep. 4, A-01)

D-85.000 Death and Vital Records
(See also: Ethics)

D-85.997 Lessons Learned from Terri Schiavo

1. Our AMA will communicate with key health insurance organizations, both private and public, to encourage them and their institutional members to include information regarding advance directives and related forms and will also communicate with state Departments of Motor Vehicles to recommend the distribution of information about advance directives to individuals obtaining or renewing a driver's license.

2. Our AMA Ethics Resource Center will update its web content regarding advance directives, including links to other appropriate resources with permission from the relevant organizations. (BOT Rep. 22, A-06)

D-85.998 Certification of Cause of Death

Our AMA shall work with the: (1) Centers for Disease Control and Prevention's National Center for Health Statistics and state medical societies in Washington, Montana, and Oregon to resolve the present inconsistencies in these states with respect to national and international protocols for certification to cause of death on the death certificate; and (2) Federation to educate state legislators on the need for uniformity in cause of death statistics and the appropriate role physicians play in the certification of the cause of death (Sub. Res. 419, A-02)

D-85.999 Accuracy, Importance, and Application of Data from the U.S. Vital Statistics System

Our AMA: (1) in cooperation with state and local medical societies, will encourage states to adopt the changes recommended in the latest revision of the U.S. Standard Certificates of Live Birth, Death, and Report of Fetal Death, planned for implementation in January 2003;

(2) will assist the National Center for Health Statistics (NCHS) and others in making physicians aware of impending changes to the U.S. Standard Certificates, such as the addition of the question on tobacco-related mortality to the medical certification of death;

(3) will urge state and specialty medical societies to pursue local policies and/or legislative changes that would enhance the accuracy of vital records in the United States;

(4) will work with the NCHS, the American College of Obstetrics and Gynecology (ACOG), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP) to develop guidelines for physician responsibility in the medical certification of live birth and fetal death;

(5) in association with state and local medical societies, will recommend that state departments of vital statistics adopt uniform policies that ensure the confidentiality of health and medical information on certificates of live birth, fetal death, and death, with consideration given to anticipated guidelines for the electronic transfer of data;

(6) will recommend that states work quickly to adopt electronic registration of vital events to enable detailed instructions, help screens, and real-time edit checking as a means to improve the accuracy and timeliness of data on U.S. vital records; and.

(7) will notify state and local medical societies, state departments of vital statistics, and the NCHS of our policies concerning revised vital records. (CSA Rep. 6, I-00)

D-90.000 Disabled

D-90.993 Fitness and Athletics Equity for Students with Disabilities

Our AMA will work with state medical associations and specialty societies to encourage individual state legislatures to enact laws which ensure that students with disabilities have an equal opportunity to participate in mainstream physical education programs and try out for and, if selected, participate in mainstream athletic programs, except when the inclusion of the student presents an objective safety risk to the student or to others, or fundamentally alters the nature of the school's mainstream physical education or mainstream athletic program. (Res. 202, A-08)

D-90.994 Threats Against Physicians Based on Americans With Disabilities Act

Our AMA encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA's Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents. (BOT Rep. 6, I-05)

D-90.995 Early Intervention for Children with Developmental Delay

Our AMA will work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and urges physicians to assist parents in obtaining access to appropriate individualized early intervention services. (Res. 419, A-05; Reaffirmed in lieu of Res. 535, A-06)

D-90.996 Increase Funding for School and Preschool Services for MRDD Children

Our AMA will seek passage of federal regulation and/or legislation increasing school funding for services for preschool and school-aged mentally retarded/developmentally disabled children in the educational setting. (Res. 432, A-05; Reaffirmed in lieu of Res. 535, A-06)

D-90.997 Reimbursement for Sign Language Interpreters

Our AMA will make it a priority for the 2002 Congressional session that legislation be enacted to provide that Medicaid and private insurance be required to adequately reimburse interpreters for the cost of their services. (Res. 204, I-01)

D-90.998 Establishing Disability in Various Stages of HIV Infection

Our AMA advocates further study to define the residual function and limitations associated with impairments (CSA Rep. 8, I-99)

D-90.999 Interpreters For Physician Visits

Our AMA: (1) seeks enactment of the proposed legislation to clarify the provisions in the Americans with Disabilities Act (ADA) requirement relating to the provision of qualified interpreters for hearing impaired patients; and (2) continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients. (BOT Rep. 15, I-98; Reaffirmation I-03)

D-95.000 Drug Abuse
(See also: Alcohol and Alcoholism; Accident Prevention: Motor Vehicles; Pregnancy)

D-95.981 Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction

Our AMA:

1. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;

2. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;

3. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;

4. will consult with relevant agencies on potential strategies to actively involve physicians in being “a part of the solution” to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and

5. supports research on: (a) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (b) issues relevant to the long-term use of prescription controlled substances. (CSAPH Rep. 2, I-08)

D-95.982 Drug Abuse and Relapse Reduction Through Patient Identifiers

Our AMA: (1) strongly urges health care providers to take an active role in acknowledging the diagnosis of addiction; and (2) will partner with organizations such as the American Society of Addiction Medicine, to explore the use of medication contracts to monitor the use of prescribed medications in patients with a known history of addiction. (Res. 420, A-08)

D-95.983 Mandatory Drug Screening Reporting

Our AMA will: (1) work with appropriate state and specialty medical societies and with state legislative bodies to ensure that physicians not be required to report patients with positive drug screen results to the police; and (2) continue to promote education of physicians regarding the importance of referring patients found to have positive urine drug screens for appropriate medical treatment. (Res. 406, A-08)

D-95.984 Substance Use and Substance Use Disorders

Our AMA:

(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;

(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and

(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use

disorders. (CSAPH Rep. 8, A-08)

D-95.985 Substance Use Disorder is a Disease

Our AMA will study ways in which it can be supportive in communicating the reality of the concepts that substance use disorder is: (1) a potentially lethal but treatable disease; and (2) one that may be preventable with early education and intervention. Efforts should be directed at youth to help them understand the diseases and their treatments and to stave off peer pressure to experiment with potentially addictive substances. (Res. 421, A-07)

D-95.986 Background on the Organization "Physicians and Lawyers for National Drug Policy" (PLNDP)

Our AMA will: (1) express support to Physicians and Lawyers for National Drug Policy (PLNDP) for including in its statement of policy priorities the need for parity in insurance payments for addiction treatment; (2) encourage physicians to partner with lawyers and judges in their communities to become Lawyer and Physician Associates of PLNDP at no cost, and to work collaboratively in their communities to promote a more rational, public-health-focused approach to substance use and addiction; and (3) encourage individual members to join or collaborate with PLNDP efforts when they are consistent with and supportive of AMA policy goals. (BOT Rep. 8, A-07)

D-95.987 Intranasal Naloxone Administration

Our AMA: (1) recognizes the great burden that opiate addiction and abuse places on patients and society alike and reaffirms its support for the compassionate treatment of patients with opiate addiction; and (2) will monitor the progress of intranasal naloxone studies and report back as needed. (Res. 526, A-06)

D-95.988 Methamphetamine Epidemic in America

Our AMA will work with appropriate organizations to study the problem of methamphetamine use and addiction, and develop recommendations to address this emerging health problem. (Sub. Res. 826, I-05)

D-95.989 Support for the National Council on Alcoholism and Drug Dependence Public Awareness Campaign

Our AMA will support the National Council on Alcoholism and Drug Dependence's public awareness campaign designed to educate the public about misperceptions concerning the origins of and treatment for substance use disorders. (Res. 801, I-05)

D-95.990 Dextromethorphan Abuse

Our AMA will:

(1) recommend that the Federal Trade Commission consider taking actions against purveyors of bulk dextromethorphan for sale to individuals, particularly those committing unfair or deceptive acts in conducting business over the Internet;

(2) assist the Consumer Healthcare Products Association and the Partnership for a Drug-Free America in publicizing their educational efforts and resources on dextromethorphan abuse;

(3) support legislation preventing the over-the-counter sale of dextromethorphan products to individuals under the age of 18;

(4) publicize CSA Report 1 (I-04) and make it readily available to physicians who treat adolescents and to the public; and

(5) monitor emerging data on the extent of dextromethorphan abuse and respond as appropriate. (CSA Rep. 1, I-04)

D-95.991 Dextromethorphan Abuse

Our AMA will issue a statement of concern regarding the sale of bulk Dextromethorphan (DXM) via the Internet to the general population; and will support legislation outlawing the sale of bulk DXM to the general population, especially via the Internet. (Res. 528, A-04)

D-95.992 Study of Abuse of Medications Containing Dextromethorphan

Our AMA will: (1) study, in consultation with the Food and Drug Administration (FDA), the Drug Enforcement Administration (DEA), the over-the-counter pharmaceutical industry, and other appropriate organizations, the status of abuse of medications containing dextromethorphan among adolescents in the United States, with a report back at the 2004 Interim Meeting including recommendations regarding dissemination of the findings to physicians and the general public; and (2) strongly request that the FDA,

the DEA, and other appropriate government authorities use every means possible to halt bulk sales of dextromethorphan over the Internet. (Sub. Res. 708, I-03)

D-95.993 Safe Disposal of Used Needles and Syringes in the Community: Update on AMA Activities

Our AMA shall: (1) continue to implement the recommendations of Council on Scientific Affairs Report 2 (A-01);

(2) support the mission of the newly established Coalition for Safe Community Needle Disposal. The mission statement is:

(a) The Coalition for Safe Community Needle Disposal is dedicated to the safe disposal of syringes and needles used by individuals in their homes and communities.
(b) Every year, more than 2 billion needles and syringes are used outside of healthcare settings. Improperly disposed needles and syringes are a hazard to workers and the public.
(c) The coalition is a collaboration of businesses, community groups, and government that promotes public awareness and solutions for safe disposal of needles and syringes in the community.

(3) support the activities of the newly established Coalition for Safe Community Needle Disposal, which include producing the following materials:

(a) Guidelines for successful coalition building;
(b) A list of frequently asked questions with appropriate answers for health care professionals regarding community needle and syringe disposal;
(c) discussion paper on the potential impact of the Occupational Safety and Health Administration's Bloodborne Pathogens Standard on community safe needle and syringe dispoal programs;
(d) A istof programs already in existence, with the appropriate contact information;
(e) A list of Web sites and listservs that detail and discuss community safe needle and syringe disposal programs;
(f) Fifty state-level guides describing and discussing all state legislation and regulations that may affect the implementation of a community safe needle and syringe disposal program;
(g) A list of state and regional chapters/associations of the seven organizations working on the problem-identification statement; and
(h) A list of peer-reviewed references on safe community needle and syringe disposal. (CSA Rep. 3, A-02)

D-95.994 Safe Disposal of Used Syringes, Needles, and Other Sharps in the Community

(1) Our AMA will support action at the national, state, and local levels of government in collaboration with the solid waste industry, sharps and pharmaceutical manufacturers, and pharmaceutical distributors and appropriate health care organizations, including local, state and medical specialty societies, to identify, develop, implement, and evaluate strategies to ensure safe sharps disposal in the community.

(2) Our AMA will continue to maintain an active presence in national efforts to develop solutions to the problem of safe sharps disposal in the community.

(3 A report on our AMA's ongoing activities on this issue be prepared for the Annual 2002 meeting of the House of Delegates. (CSA Rep. 2, A-01)

D-95.995 Safe Disposal of Used Syringes and Needles

Our AMA will review the literature and existing policies on the public and occupational health hazards of used syringes and needles outside of healthcare settings and prepare a report with recommendations on how to ensure proper disposal of used needles/syringes outside of healthcare settings. (Res. 415, A-00)

D-95.996 Consensus Statement of the Physician Leadership On National Drug Policy

Our AMA endorses the 1997 Consensus Statement of the Physician Leadership on National Drug Policy as a rational approach to informing national drug policy on illegal drugs. (CSA Rep. 9, I-99)

D-95.997 Altered Illicit Substances

Our AMA will pursue appropriate revisions of the relevant federal laws and regulations as a means of interdicting the manufacture, distribution or sale of such substances. (Sub. Res. 401, I-99)

D-95.998 Physicians as Patients: their Right to Confidentiality

Our AMA will continue to work with the American Society of Addiction Medicine, the American Psychiatric Association, and other interested organizations to address concerns regarding substance abuse among physicians. (BOT Rep. 17, I-99)

D-95.999 Reduction of Medical and Public Health Consequences of Drug Abuse: Update

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance treatment services and programs in their states. (CSA Rep. 12, A-99)

D-100.000 Drugs
(See also Drugs: Advertising; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing; Drugs: Substitution)

D-100.975 One Fee One Number

1. Our AMA will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, provider should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program.

2. Our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single state requirements.

3. Our AMA continues to monitor implementation of the National Provider Identifier (NPI) system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database. (BOT Rep. 5, I-08)

D-100.976 Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance

Our AMA will work with interested partners to develop new, or improve existing, FDA guidelines concerning the prudent use of antibiotics in livestock to protect patients from the dangers of antimicrobial-resistant pathogens. (Res. 530, A-08)

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)

D-100.978 FDA Drug Safety Policies

Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. (Sub. Res. 505, A-08)

D-100.979 Anti-aging Medications

Our AMA Council on Science and Public Health will undertake a review of "anti-aging" medications, their efficacy, benefits, and risks, and report back to the House of Delegates. (Res. 501, A-08)

D-100.980 One Fee, One Number

Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific. (Res. 701, I-07)

D-100.981 Security of DEA Numbers and National Provider Identifier Information

Our AMA will:

(1) work with the Drug Enforcement Administration (DEA) and Congress to assure that DEA numbers are not readily available to the public for commercial or other purposes not essential for prescribing verification;

(2) continue efforts to work with the Centers for Medicare and Medicaid Services regarding the security, dissemination and integrity of the National Provider Identifier (NPI);

(3) report back to the House of Delegates at the 2006 Annual Meeting, and annually thereafter for five years, on the outcome of these efforts to assure that DEA numbers and the NPI are only available and used for their intended purposes; and

(4) undertake a widespread campaign to inform physicians that the use of DEA numbers for purposes of identification other than for prescription of controlled substances is inappropriate and that this campaign be positioned to inform the various entities which inappropriately request DEA numbers. (Res. 905, I-05; Reaffirmation A-06)

D-100.982 Enhanced Physician Access to Food and Drug Administration Data

Our AMA will:

(1) Urge the Food and Drug Administration to issue a final rule, as soon as possible, implementing modifications to the format and content of the prescription drug package insert with the goal of making the information more useful and user-friendly to physicians;

(2) urge the FDA to collaborate with physician organizations to develop better risk communication vehicles and approaches;

(3) urge the FDA to apply new tools to gather data after drugs are approved for marketing, including a broader use of targeted post-approval studies, institution of active and sentinel event surveillance, and data mining of available drug utilization databases;

(4) monitor the design and implementation of any independent drug safety board that may be instituted within the FDA, or external to the agency, and respond as appropriate; and

(5) support adequate funding to implement an improved FDA postmarketing prescription drug surveillance process. (CSA Rep. 6, A-05)

D-100.983 Prescription Drug Importation and Patient Safety

Our AMA will:

(1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported;

(2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured;

(3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation; and

(4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts. (BOT Rep. 3, I-04)

D-100.984 Access to FDA Data Regarding the Safety and Efficacy of Medications

Our AMA will ask the Council on Scientific Affairs to (1) study the issue of enhancing access to Food and Drug Administration data regarding the safety and efficacy of medications, and (2) develop recommendations designed to improve access to clinically relevant research collected by the FDA. (Res. 529, A-04)

D-100.985 Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient

Our AMA will: (1) continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting; and (2) work with the Congress, the Food and Drug Administration, the Drug Enforcement Administration, and other federal agencies, the pharmaceutical industry, and other stakeholders to ensure that these illegal activities are minimized. (Res. 501, A-04; Reaffirmation I-06)

D-100.986 FDA Rejection of Over-The-Counter Status for Emergency Contraception Pills

Our AMA will: (1) issue a public statement to oppose the unprecedented actions of the Acting Director of the United States Food and Drug Administration in overruling the approval of over-the-counter access to the Plan B pill, and urge the reconsideration of this decision immediately; (2) work with the American College of Obstetricians and Gynecologists, Physicians for Reproductive Choice and Health, local and state medical societies, and other interested organizations to continue its efforts to increase access to emergency contraception, including further lobbying of the FDA and Congress to make emergency contraception available over-the-counter; and (3) report back on the issue of increasing access to emergency contraception at the 2004 Interim Meeting. (Res. 443, A-04)

D-100.987 DEA Number

Our AMA will (1) make a renewed effort to stop the misuse of Drug Enforcement Administration (DEA) numbers by petitioning the US Department of Justice and/or any other appropriate federal agency to seek an immediate injunction or any other appropriate legal remedy to limit the use of DEA numbers to controlled substance prescriptions only; and (2) vigorously implement Policy H-100.972 regarding the appropriate use of DEA numbers. (Sub. Res. 208, A-04; Reaffirmation A-06)

D-100.988 Tracking and Punishing Distributors of Counterfeit Pharmaceuticals

Our AMA will support the Food and Drug Administration's efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals. (Res. 924, I-03; Reaffirmation I-06)

D-100.989 Pharmaceutical Shortages

Our AMA will continue to work with the federal government and other key stakeholders to develop and implement strategies that will prevent shortages of drugs, vaccines, and other medical products, and that will more effectively resolve shortages when they occur (BOT Rep. 2, A-03)

D-100.990 Patient Privacy and Pharmaceutical Sales Representatives

Our AMA will work in conjunction with representatives of the pharmaceutical industry to promulgate appropriate guidelines to protect patient privacy and confidentiality and to prevent inappropriate intrusion into the doctor/patient relationship (Res. 8, A-03; Reaffirmed: BOT Rep. 24, I-04)

D-100.991 Statutory Authorization of the Pediatric Rule

Our American Medical Association shall advocate that Congress authorize the Food and Drug Administration to require evaluation by pharmaceutical companies of safety and efficacy of appropriate new and marketed drugs in children. (Res. 724, I-02)

D-100.992 Drug, Diagnostic Agent, and Vaccine Shortages: An Update

Our AMA shall continue to implement the recommendations of Board of Trustees Report 7, Drug, Diagnostic Agent, and Vaccine Shortages (I-01). (BOT Rep. 17, A-02)

D-100.993 Drug and Vaccine Shortages

Our AMA will:

(1) ask the Secretary of Health and Human Services to: (a) establish a departmental task force to explore the causes of drug, diagnostic agent, and vaccine shortages and maldistribution and to identify appropriate solutions to these problems (including liability, reimbursement, and availability to the most vulnerable populations) so that the health of the public is adequately protected. This task force should include (but is not limited to) representatives from the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Research and Quality (AHRQ); (b) require this task force to seek the input of the pharmaceutical industry, wholesalers/distributors, physician and pharmacy organizations, and consumers in addressing the problem of drug, diagnostic agent, and vaccine shortages; and (c) as part of this initiative, commission one or more studies by an appropriate body of experts to identify and recommend solutions for the underlying breakdowns in both the drug, diagnostic agent, and vaccine manufacturing and distribution systems that lead to shortages;

(2) work with the FDA to expand its list of "medically necessary products" to be more inclusive of important medicines, vaccines, and diagnostic agents; and will urge the FDA to monitor production, inventory, and planned cessation of production of "medically necessary products" in order to more effectively intervene when the public health is threatened.

(3) will work with the FDA to educate physicians on how to report potential drug and vaccine shortages to the Agency;

(4) in collaboration with the Federation, the FDA, the CDC, the pharmaceutical industry, and pharmacy associations, determine the feasibility, including costs, of establishing an effective means to communicate timely information about drug and vaccine shortages, including information about alternative therapies, to physicians; and

(5) report back to the HOD at 2002 Annual Meeting. (BOT Rep. 7, I-01; Reaffirmation A-05)

D-100.994 Physician Prescribing Data and Use of DEA Activities

Our AMA will continue its legislative efforts to limit use of the DEA numbers to federal agencies authorized to enforce the laws regarding manufacture, distribution, and dispensing of controlled substances. (BOT Rep. 11, I-01; Reaffirmation A-06)

D-100.995 Antimicrobial Use and Resistance

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

D-100.996 Expediting Access to Promising Investigational Drugs

Our AMA will: (1) work with the FDA to disseminate information to physicians and their patients about the FDA's expedited approval process for and methods for obtaining promising, investigational drugs; and (2) urge the FDA to consider additional ways to expand access to promising, investigational drugs. (Sub. Res. 518, I-00)

D-100.997 Use of Antimicrobials in Consumer Products

Our AMA will: (1) encourage the Food and Drug Administration (FDA) to expedite their regulation of the use in consumer products of antimicrobials for which acquired resistance has been demonstrated; (2) monitor the progress of the current FDA evaluation of the safety and effectiveness of antimicrobials for consumer use in over-the-counter (OTC) hand and body washes; and (3) encourage continued research on the use of common antimicrobials as ingredients in consumer products and its impact on the major public health problem of antimicrobial resistance. (CSA Rep. 2, A-00)

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

Our AMA will continue to collaborate with the appropriate federal agencies, other medical specialty societies, and other appropriate public health organizations to address the urgent problem of increasing antimicrobial resistance and its impact on public health. (CMS Rep. 3, A-00; Reaffirmation I-07)

D-100.999 Costs and Benefits of Pharmaceutical use in the United States

Our AMA will encourage the FDA to carefully monitor the manufacturing quality, bioavailability and efficacy, and the Federal Trade Commission to carefully monitor the pricing of generic pharmaceuticals within the United States. (CMS Rep. 9, I-99)

D-105.000 Drugs: Advertising
(See also: Drugs; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing; Drugs: Substitution)

D-105.997 E-Commerce and Unsolicited E-mails

To supplement the already significant ongoing efforts to limit unsolicited e-mail advertising of pharmaceuticals, our AMA will advocate the use of an already established federal e-mail address (currently: uce@ftc.gov) where unsolicited e-mails may be sent for appropriate investigation. (Res. 514, A-04)

D-105.998 Direct to Consumer Advertising

Our AMA will request the appropriate federal agency to enforce the direct-to-consumer advertising guidelines and regulations according to AMA Policy H-105.998. (Res. 714, I-03)

D-105.999 Direct to Consumer Drug Advertising

Our AMA will collaborate with the National Council for Patient Information and Education or other appropriate broad-based groups to develop and disseminate materials to educate consumers and physicians about the risks, benefits, detriments, and potentially misleading information provided in direct-to-consumer advertisements. (Sub. Res. 503, A-01)

D-110.000 Drugs: Cost
(See also: Drugs; Drugs: Advertising; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing; Drugs: Substitution)

D-110.989 Payment for Biologics and Pharmacologic Agents

Our AMA will: (1) study the inability of practicing physicians to obtain payment (including drugs and their managerial acquisition costs) for biologics and pharmacologic agents at the rates intended by Congress; and (2) make recommendations directly to the Centers for Medicare and Medicaid Services to correct inadequate payment for biologics and pharmacologic agents and their managerial acquisition costs. (Res. 721, I-07)

D-110.990 Study of Cost Sharing Arrangements in Prescription Benefits

Our AMA will study the relative advantages and disadvantages of two models of patient cost sharing in prescription benefits, namely fixed dollar co-payments and percentage-based coinsurance, and recommend a plan of action that will advocate for better containment of price inflation and greater freedom for patients to obtain the best prescriptions for their disorders, with a report back to the AMA House of Delegates at the 2007 lnterim Meeting. (Res. 816, I-06)

D-110.991 Economic and Health Value of Drugs

Our AMA will (1) encourage the Agency for Healthcare Research and Quality (AHRQ) to have the Centers for Education and Research on Therapeutics program coordinate independent research to assess the health and economic value of prescription drugs, and that the AHRQ adequately fund this initiative; and (2) monitor these activities and assist as appropriate. (BOT Action in response to referred for decision Res. 510, A-01)

D-110.992 Fourth Tier Pharmaceutical Benefits

Our AMA will (1) investigate the prevalence and impact in the health insurance industry of tiered pharmaceutical benefits that significantly affect patients who have diseases requiring expensive drugs for their treatment, and report back to the House of Delegates at the 2005 Interim Meeting; and (2) work with the insurance industry to ensure that patients with catastrophic diseases have an upper limit on copayments and deductibles sufficient to keep therapy affordable. (Res. 835, I-04; Reaffirmation A-08)

D-110.993 Reducing Prescription Drug Prices

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation, and the AMA's Advocacy Resource Center for materials from its "Access to Affordable Prescription Drugs" campaign. (CMS Rep. 3, I-04)

D-110.994 Inappropriate Extension of Patent Life of Pharmaceuticals

Our AMA will continue to monitor the implementation of the newly-enacted reforms to the Hatch-Waxman law to see if further refinements are needed that would prevent inappropriate extension of patent life of pharmaceuticals, and work accordingly with Congress and the Administration to ensure that AMA policy concerns are addressed. (BOT Rep. 21, A-04)

D-110.995 Marketing and Research by Pharmaceutical Companies

Our AMA will work with appropriate federal and private organizations to establish uniform methods for reporting cost-benefit outcomes, so that cost-benefit statements made in marketing activities by pharmaceutical companies are consistent and easily understood. (Sub. Res. 4, I-01)

D-110.996 Study of Actions to Control Pharmaceutical Costs

Our AMA will study the effects of various state actions to control pharmaceutical costs, such as pharmaceutical discounts, rebate programs, price control legislation, and large group purchasing coalitions, including how such arrangements affect the costs of prescription drugs. (Sub. Res. 114, A-01)

D-110.997 Pharmaceutical Spending in the United States

(1) Our AMA will encourage employers and health plans to analyze and disaggregate their data on pharmaceutical spending in order to better understand the underlying causes of recent spending increases, and to develop corresponding strategies that do not adversely

affect patient access to necessary pharmaceuticals nor impose undue administrative burdens.

(2) Consistent with Policies H-110.996[1] and H-110.998, our AMA will strongly encourage members of the pharmaceutical industry to independently identify, develop, and implement, market-based solutions to addressing those factors contributing to the rapid growth in pharmaceutical spending for which they have control, such as marketing campaigns and the pricing strategies for their product lines.

(3) Our AMA will strongly encourage the pharmaceutical industry to adhere to the direct-to-consumer advertising guidelines for prescription drugs developed by our AMA (Policy H-105.988[1]).

(4) Our AMA will provide information to physicians on how to report potential inaccurate and/or inappropriate direct-to-consumer advertising of prescription drugs to the Food and Drug Administration.

(5) Our AMA will encourage the pharmaceutical industry to expand its methods of communicating with patients and physicians regarding how potentially eligible patients can access free prescription drug programs, and make such access free of unnecessary delays, which may be detrimental to the patient's health and may hinder the physician's ability to procure necessary drugs for his or her patients.

(6) Our AMA will work to increase physician awareness of, and provide physicians with information about, free prescription drug programs and the organizations that help patients and physicians utilize these programs.

(7) Our AMA will encourage physicians and patients who believe they have experienced potential therapeutic failures with generic drugs to report such experiences to the Food and Drug Administration through a federally-funded toll-free telephone number for possible investigation by its Therapeutic Inequivalence Action Coordinating Committee.

(8) Our AMA will continue to monitor and study all factors relating to increasing pharmaceutical costs in the United States, including issues such as marketing to physicians and the effects of litigation on costs, and report back to the House of Delegates on a periodic basis. (CMS Rep. 3, I-00)

D-110.998 Pharmaceutical Costs

(1) Our AMA will study the problem of increasing pharmaceutical costs, at a minimum, addressing: (a) international differences in prices paid for identical drugs, (b) introduction of new pharmaceuticals that are significantly more expensive than the ones they replace, (c) direct-to-consumer advertising, (d) lifestyle drugs such as Viagra, Propecia, etc. (e) the bioavailability, equivalency and efficacy of generic drugs and, (f) impaired access to necessary pharmaceuticals for all patients.

(2) Our Council on Medical Service will study and recommend changes in United States laws to permit the purchase of FDA approved drugs across national borders by individual United States citizens and more importantly to permit pharmacies to purchase wholesale such drugs from foreign suppliers and to report back to the House at A-2000. (Sub. Res. 123, I-99)

D-110.999 Proprietary and Generic Drug Pricing

Our AMA will: (1) review the sudden and significant price increases in the generic drug industry with the American Pharmacists Association and trade associations representing generic drug manufacturers and other entities and bring any inappropriate marketing, dispensing or incentive practices to the attention of regulatory agencies; and (2) restudy and report at Annual 2000, the foreign and domestic pricing of proprietary and generic pharmaceuticals. (Res. 522, A-99)

D-115.000 Drugs: labeling and Packaging
(See also: Drugs; Drugs: Advertising; Drugs: Cost; Drugs: Prescribing and Dispensing; Drugs: Substitution)

D-115.990 Patient Prescriptions

Our AMA will work with relevant organizations to improve prescription labeling for visually or otherwise impaired patients and to increase awareness of available resources. (Res. 914, I-08)

D-115.991 Manufacturer Labeling of Medical Supplies

1. Our AMA will seek the passage of regulation and/or legislation that mandates that all manufacturers of sterile medical equipment sold or manufactured in the United States have an easily readable, clearly stamped expiration date on the package.

2. Our AMA encourages the Food and Drug Administration to require appropriate standardization of expiration dates across medical supplies so that such expiration dates will be better understood. (Res. 214, A-07; Modified: Sub. Res. 517, A-08)

D-115.992 Safety and Efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs) in Children and Adolescents

Our AMA will urge the Food and Drug Administration to evaluate the impact of labeling changes mandated by the Agency for antidepressants, including the Black Box warning and Patient Medication Guide on treatment patterns, patient compliance, and patient access. (CSA Rep. 10, A-05)

D-115.993 Standardization of Appearance, Concentration, and Packaging of Common Classes of Pharmaceuticals

Our AMA will collaborate with the National Patient Safety Foundation, the Anesthesia Patient Safety Foundation, the Food and Drug Administration, and other interested parties to explore the value of promoting the standardization of the appearance, concentration and packaging of common classes of pharmaceuticals. (Res. 504, A-04)

D-115.994 The Role of Color Coding in Medication Error Reduction

Our AMA will recommend to the Food and Drug Administration, the United States Pharmacopeia, and the pharmaceutical industry that color coding of pharmaceutical products for the purpose of preventing medication errors be considered cautiously on a case-by-case basis and will encourage further research on the effectiveness of color coding of pharmaceutical products in reducing medication errors. (CSA Rep. 5, A-04)

D-115.995 Readable Pharmaceutical Drug Inserts and Attachments to Drug Advertisements

Our AMA will continue to urge the Food and Drug Administration to issue a Final Rule that would revise the Package Insert (PI), per its December 2000 Proposed Rule, in order to make it more readable and understandable for the public and healthcare professionals. (Sub. Res. 504, A-03)

D-115.996 Pharmaceutical Expiration Dates

Our CSA will monitor this activity and report to the House at A-01. (Res. 527, A-00)

D-115.997 Imprinting of Medications

Our AMA will explore and consider again joining with other interested organizations, including the United State Pharmacopeia, in seeking to encourage the Food and Drug Administration to reconsider its current policy allowing characters or symbols which are other than alphanumeric to be used in the imprint coding on solid medication forms, with the goal of enabling computer-based and telephonic systems to much more readily, widely and accurately "decode" specific medications. (Res. 529, A-00)

D-115.998 Labeling of Prescription Drug Containers for Generic-Substituted Drugs

Our AMA will send CSA Report 2, I-99, "Labeling of Prescription Drug Containers for Generic-Substituted Drugs", as expeditiously as possible, to the National Association of Boards of Pharmacy. (CSA Rep. 2, I-99)

D-115.999 Domestic Violence Prevention Information and Movie Theaters

Our AMA will study the Baltimore County Medical Association’s experience with their public service domestic violence awareness and referral initiative using movie theater promotions and, if appropriate, facilitate other county and state medical associations and Alliances in the implementation of similar programs by making them aware of the Baltimore programs. (Res. 419, I-99)

D-120.000 Drugs: Prescribing and Dispensing
(See also: Drugs; Drugs: Advertising; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Substitution)

D-120.957 Electronic Prescribing Incentive Program

Our AMA will continue to work with CMS to ensure that the Electronic Prescribing Incentive Program policies and reporting procedures provide the greatest flexibility to physicians who electronically prescribe and elect to participate in the program. (Res. 223, I-08)

D-120.958 Federal Roadblocks to E-Prescribing

1. Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, “brand medically necessary” on a paper prescription form.

2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs.

3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of E-prescribing

4. Our AMA will work with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions

5. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption. (Res. 230, A-08; Reaffirmed in lieu of Res. 215, I-08)

D-120.959 Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals

Our AMA urges the Centers for Medicare and Medicaid Services to immediately simplify the current Part D Prescription Drug Program Appeal Process by allowing physicians to submit an appeal without beneficiary approval. (Res. 212, A-08)

D-120.960 Internet Prescriptions

Our AMA will continue to advocate for its model federal legislation on Internet prescribing as the best means to effectively regulate the sale of prescription drugs, including controlled substances, over the Internet. (Sub. Res. 506, A-08)

D-120.961 Personal Medication Supply in Times of Disaster

Our AMA urges the appropriate federal agencies to convene a meeting of medical societies, health care organizations, and other stakeholders to: (a) develop a national plan to ensure timely distribution of and access to medications for chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, which provides the essential health and medical information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency. (BOT Rep. 15; A-08)

D-120.962 Joint Commission Interpretations of Medication Reconciliation and Other Standards

Our AMA will: (1) advocate that all Joint Commission standards, including medication reconciliation standards, be consistently interpreted by its survey team members, hospitals, and health care systems to improve patient safety; and (2) work with other interested parties, including state and medical specialty societies, the American Hospital Association, National Patient Safety Foundation and The Joint Commission to standardize interpretation and enforcement of Joint Commission medication reconciliation policies, based on pre-established, uniform, specific, and consistently interpreted criteria. (Res. 815, I-07)

D-120.963 Patient Access to Off-Label Use of Avastin

Our AMA will: (1) oppose Genentech's efforts to prevent compounding pharmacies from directly purchasing Avastin (bevacizumab) in the interest of patient access to off-label treatments as a "practice of medicine" issue, as well as any interference by Genentech in the physician-patient relationship; and (2) express opposition by means including but not limited to sending a letter to Genetech and issuing a press release. (Res. 819, I-07)

D-120.964 Standardized Pharmacy Telephone Answering Machines

Our AMA will work with pharmacy executives of companies who have a multi-state presence, to standardize the pharmacy voice-mail message which would allow the physician caller to bypass the entire message and select the choice to phone in a prescription. (Res. 809, I-07)

D-120.965 Pharmacy Review of First Dose Medication

1. Our AMA supports medication reconciliation as a means to improve patient safety.

2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting. (BOT Action in response to referred for decision Res. 808, I-06)

D-120.966 Pharmacists' Refusal to Fill Legally Valid Prescriptions

Our AMA will (1) prepare a report summarizing the available information regarding delays or difficulties patients have experienced due to pharmacists' refusal to fill legally valid prescriptions; and (2) develop specific recommendations to ensure that patients' prescriptions are filled in a timely and appropriate manner. (Res. 13, A-07)

D-120.967 Accutane "I Pledge" Program

Our AMA will partner with other interested organizations such as the American Academy of Dermatology to survey the Accutane "I Pledge" Program to ascertain problems and reasons for patient dropout in order to make the program user-friendly to patients and doctors. (Res. 516, A-07)

D-120.968 Pharmacy Review of First Dose Medication

1. Our AMA will advocate with the Joint Commission on Accreditation of Healthcare Organizations and other appropriate bodies to revise JCAHO's medication reconciliation standard (MM 4.10) and its National Patient Safety Goal 8 (NPSG8) so that medication administered in a hospital setting does not require first dose review by a pharmacist.

2. It is AMA policy that a pharmacist should be available in person or by other means for consultation when medication is administered in a hospital setting. (Res. 808, I-06)

D-120.969 FDA Oversight of Bioidentical Hormone (BH) Preparations

Our AMA will:
(1) urge the Food and Drug Administration (FDA) to conduct surveys for purity and dosage accuracy of all compounded "bioidentical hormone" formulations;
(2) urge the FDA to require mandatory reporting by drug manufacturers, including compounding pharmacies, of adverse events related to the use of "bioidentical hormones";
(3) urge the FDA to create a registry of adverse events related to the use of compounded "bioidentical hormone" preparations;
(4) request that the FDA require the inclusion of uniform patient information, such as warnings and precautions, in packaging of compounded "bioidentical hormone" products; and
(5) urge the FDA to prohibit the use of the term "bioidentical hormones" unless the preparation has been approved by the FDA. (Res. 706, I-06)

D-120.970 Prescription Requirements for Schedule II (C-II) Controlled Substance for a Hospice Patient

Our AMA will take action to see that federal legislation is passed to amend DEA regulation 21 CFR 1306.11 to allow for pharmacies to fill an oral or computer-generated electronic prescription for a Schedule II (C-II) controlled substance for a hospice patient. (Res. 531, A-06)

D-120.971 Promoting Pain Relief and Preventing Abuse of Controlled Substances

Our AMA will:
(1) urge the Drug Enforcement Administration (DEA) to publicly restate their commitment to balance in promoting pain relief and preventing abuse of pain medications;
(2) support an ongoing constructive dialogue among the DEA and physician groups to assist in establishing a clinical practice environment that is conducive to pain management and the relief of suffering, while minimizing risks to public health and safety from drug abuse or diversion;
(3) strongly urge that the DEA's upcoming recitation of the pertinent legal principles relating to the dispensing of controlled substances for the treatment of pain maintain a patient-centered focus, including reaffirmation of its previous interpretation of law to permit practitioners to issue a series of prescriptions marked "do not fill" until a later date; and
(4) strongly urge that the DEA should promulgate, in consultation with relevant medical specialty societies and patient advocacy groups, a rational and realistic set of FAQs to assist in providing education to health care practitioners and law enforcement and regulatory personnel about appropriate pain management, and measures to be taken to minimize drug abuse and diversion. (BOT Rep. 3, A-06)

D-120.972 Electronic Prescribing

Our AMA will (1) ask the Drug Enforcement Administration to accelerate the promulgation of digital certificate standards for direct electronic transmission of controlled substance prescriptions to support the patient safety goals and other governmental initiatives; and (2) urge Congress to work towards unifying state prescription standards and standard vocabularies to facilitate adoption of electronic prescribing. (Res. 525, A-05; Reaffirmed in lieu of Res. 215, I-08)

D-120.973 Availability of Controlled Substances Via the Internet

Our AMA will:

(1) work with the Drug Enforcement Administration to undertake discussions with e-commerce entities, including credit card companies, with the aim of stopping the unregulated flow of controlled substances over the Internet (in ways comparable to the ways that have been successfully employed to stem the flow of tobacco products to minors over the Internet); and

(2) develop model federal legislation to regulate the sale of prescription drugs, including controlled substances, over the Internet. The model legislation should include the following elements:

Internet Pharmacy. Any seller of prescription drugs over the Internet should be a licensed and Verified Internet Pharmacy Practice Sites (VIPPS)- or HHS-certified pharmacy, use only US-licensed pharmacists to dispense prescriptions, and dispense prescription drugs pursuant only to valid prescriptions as defined below.

Valid Prescription. A valid prescription must be authorized by a US-licensed physician and require a valid patient-physician relationship, as defined in AMA Policy H-120.949.

Pharmacy Disclosure. Any Internet pharmacy should disclose identifying information on its web site home page; at a minimum, this information should include name, address, and telephone number of the pharmacy; states (or countries) where the pharmacy is licensed; and names of pharmacists and their states (or countries) of licensure.

Mandatory Certification. Any Internet pharmacy should obtain mandatory certification, either through the VIPPS program of the National Association of Boards of Pharmacy (supported by the AMA in Policy H-120.956) or, alternatively, by a certification program established by the Secretary of HHS; certified Internet pharmacies should show a seal that links back to the certifying body.

Requirements of ISPs. The federal government should have the authority to require Internet Service Providers (ISPs) (e.g., Google, Yahoo) to prevent access (linkage) to noncertified Internet sites that sell prescription drugs.

Requirements of Credit Card Companies. The federal government should have the authority to require credit card companies (e.g., Visa, MasterCard) to prohibit transactions with noncertified Internet sites that sell prescription drugs. (Sub. Res. 522, A-05)

D-120.974 Safety and Efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs) in Children and Adolescents

Our AMA will urge the Food and Drug Administration to ensure that studies conducted by sponsors in pursuit of pediatric exclusivity be adequately designed and of sufficient duration to answer clinically relevant efficacy and/or safety questions that have evolved in a particular therapeutic area. (CSA Rep. 10, A-05)

D-120.975 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled

Our AMA will:

(1) work with state medical societies to support legislation to protect patients' ability to have legally valid prescriptions filled;

(2) enter into discussions with relevant associations (including but not limited to the American Hospital Association, American Pharmacists Association, American Society of Health System Pharmacists, National Association of Chain Drug Stores, and National Community Pharmacists Association) to guarantee that, if an individual pharmacist exercises a conscientious refusal to dispense a legal prescription, a patient's right to obtain legal prescriptions will be protected by immediate referral to an appropriate dispensing pharmacy; and

(3) in the absence of all other remedies, work with state medical societies to adopt state legislation that will allow physicians to dispense medication to their own patients when there is no pharmacist within a thirty-mile radius who is able and willing to dispense that medication. (Sub. Res. 6, A-05)

D-120.976 Pain Management

Our AMA will:

(1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already

have already established pain management guidelines; and (4) will disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain). (Res. 809, I-04; Appended: CSAPH Rep. 5, A-06)

D-120.977 Medicare Patient Access to Implantable Morphine Pumps

Our AMA, in collaboration with appropriate medical societies, will continue to work to address the need for appropriate treatment of patients requiring long-term pain management. (BOT Rep. 18, I-04)

D-120.978 Health Insurance Company Practice of "Brown Bagging"

Our AMA will (1) work with national oncologic/hematologic and other affected organizations to set up meetings with health insurance companies to discuss the practice of indirect, unsupervised acquisition, handling, preparation, and disposal of pharmaceuticals administered by physician practices ("brown bagging"); and (2) join national oncologic/hematologic and other organizations in meetings with the US Department of Health and Human Services to discuss patient safety concerns associated with the practice of indirect, unsupervised acquisition, handling, preparation, and disposal of pharmaceuticals administered by physician practices ("brown bagging"). (Res. 823, I-04)

D-120.979 DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution

Our AMA will:

(1) express its strongest concern to the Drug Enforcement Administration regarding the publication in the Federal Register of November 16, 2004 of the Interim Policy Statement regarding the prescribing of Schedule II opioid analgesics and other related topics;

(2) support interpreting federal law and regulation to allow physicians to continue the well-established clinical practice of writing multiple prescriptions for controlled agents on the date of a face-to-face examination with the actual date the prescriptions were issued, but also written directions for dispensing supplies of medication on future specified dates;

(3) support ongoing constructive dialogue between the DEA and clinicians, including physicians, regarding a proper balance between the needs of patients for treatment and the needs of the government to provide oversight and regulation to minimize risks to public health and safety; and

(4) continue to work with the DEA to change its policy so that a patient might receive a reasonable number of "do not fill before..." Schedule II prescriptions for those stable patients who require Schedule II drugs. (Res. 836, I-04; Appended: Sub. Res. 502, A-05)

D-120.980 Regulation of Media-Based Drug Sales Without Good Faith Medical Examination

Our AMA will develop and promote model federal legislation to eliminate the sale, without a legitimate prescription, of prescription drugs over the Internet, if such bills to establish national standards in this area are not forthcoming. (Sub. Res. 520, A-04)

D-120.981 Pharmaceutical Assistance Programs

Our AMA will study the feasibility of recommending a uniform application process and form which could be used by all pharmaceutical manufacturers offering pharmaceutical assistance programs, and the AMA Board of Trustees will report back to the House at the 2004 Annual Meeting with the results of this study. (Sub. Res. 705, I-03)

D-120.982 Illegal Online Prescribing Operations

Our AMA will: (1) support further legislative and regulatory efforts that require establishing a physician/patient relationship, as defined by the individual state boards of medicine and US governmental agencies, before prescribing medications online; and (2) in conjunction with state and specialty societies, lobby representatives of the state and federal governments to enforce existing laws and regulations that make certain online pharmaceutical practices illegal and to prosecute these companies to the full extent of the law in order to ensure these operations are effectively shut down. (Res. 921, I-03)

D-120.983 Concerning Pain Management

Our AMA will communicate to the President, the Secretary of the Department of Health and Human Services, and the Attorney General, its strong opposition to the inappropriate use of 21 Code of Federal Regulations Section 1306.04 or any other rationale that would involve placement of licensure restrictions on physicians who use opioid analgesics and other pain-reducing medications

appropriately to treat patients with pain.

To assist our AMA in opposing harassment of physicians, state medical and specialty societies will be requested to submit, to the AMA Office of General Counsel, examples of physicians who allegedly have been harassed by DEA agents for appropriate prescribing of controlled substances for pain management. (Sub. Res. 213, A-03)

D-120.984 Streamlining the Process for Prescription Refills

Our AMA will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety. (Sub Res. 522, A-03)

D-120.985 Increasing Awareness of Opioid Pain Management Treatments

Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice. (Sub. Res. 508, A-03)

D-120.986 Guidance for Physicians on Internet Prescribing

Our AMA will disseminate Policy H-120.949 to state and specialty medical societies and encourage the E-Medicine Advisory Committee (EMAC) and the eRisk Working Group on Healthcare to develop recommendations regarding the extent of authentication needed to identify patients who make electronic (online) requests for prescriptions. (BOT Rep. 7, A-03)

D-120.987 Prior Approval of Prescriptions

Our AMA shall develop policy against inappropriate prior approval mechanisms for pharmaceuticals and report back at the 2003 Annual Meeting. (Res. 521, A-02; Reaffirmation A-08)

D-120.988 Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers

Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06)

D-120.989 Mandatory Acceptance of the Currently Utilized Physician Prescription Form by Pharmacy Benefit Plan Administration

Our AMA shall forward the sentiments articulated in this resolution to pharmacy societies nationwide for their consideration and support.(See policy H-120.951) (Res. 516. A-02)

D-120.990 Military Treatment Facility Pharmacies

Our AMA will urge the Secretary of Defense to encourage pharmacies at Military Treatment Facilities (MTF) to accept and honor prescriptions by facsimile from civilian practitioners treating US military personnel, family members, and retirees, in any manner consistent with the law of the state in which the MTF is located, and federal laws governing the prescription, administration and dispensing of controlled substances. (Res. 501, I-01)

D-120.991 Physician Prescribing Data and Use of DEA Activities

Our AMA will: (1) develop best-practices guidelines addressing the use of physician-specific prescribing data to reinforce to the pharmaceutical industry the importance of responsible use of the data. These best-practices guidelines will then be attached to each AMA data license agreement; and (2) encourage physicians to report aggressive or inappropriate activities by sales representatives to our AMA. (BOT Rep. 11, I-01)

D-120.992 Medical Care Online

The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically. (CMS Rep. 4, A-01)

D-120.993 Restriction on Prescription Refills

Our AMA will work to remove restrictions on prescription refills when they are without clinical or legal basis. (Res. 512, A-01)

D-120.994 Isotretinoin

Our AMA encourages: (1) its membership to actively participate in voluntary education programs on the risks and benefits of isotretinoin; (2) its membership to incorporate these new educational programs into their practices; and (3) the Food and Drug Administration to continue to evaluate voluntary educational venues before adopting any additional risk management strategies. (Res. 510, I-00; Reaffirmed: Res. 516, A-07)

D-120.995 Access of Physician Prescribing Patterns

Our AMA will : (1) study legally appropriate means to: (a) prevent drug companies from having access to physician prescribing patterns; (b) prevent pharmacies and third party payers from releasing this physician-specific information; (c) protect patients and physicians from the use of this prescribing pattern information by pharmaceutical companies; and (d) prevent the use of DEA numbers as pharmaceutical marketing tools; and (2) report its findings at the 2001 Annual Meeting. (Sub. Res. 207, I-00; Reaffirmation A-06)

D-120.996 Non-Physician Prescribing

Our AMA: (1) in collaboration with specialty societies, will immediately develop programs to educate the public about the difference in education and professional standards between physicians and non-physician health care providers; and (2) will encourage state medical associations and other interested physician organizations to proactively use the advocacy campaign materials on scope of practice developed by the Advocacy Resource Center. (CMS Rep. 11, I-99)

D-120.997 Opposition of Government Determination of Appropriate Medical Practice

Our AMA will: (1) continue to support the Pain Relief Promotion Act of 1999 and will work with interested state and national specialty societies to improve the bill's language, as necessary; and (2) work with interested state and national specialty societies to improve Titles I and II of the Pain Relief Promotion Act of 1999 by deletion of those provisions which establish federal protocols and/or regulations for pain management and palliative care (including the proposed amendment to Section 502a of the Controlled Substances Act regarding educational and training programs for local, state, and federal personnel; Section 201(a)(2) of the proposed Act regarding the collection and dissemination of protocols and evidence-based practices for palliative care; and any other such objectional provisions of the proposed Act. (Sub. Res. 215, I-99)

D-120.998 Prescription Compliance by Pharmacies

Our AMA will work with appropriate professional societies, legislative and regulatory bodies to assure that pharmacies who restrict certain class of drugs from their inventory notify patients of such restrictions and offer to refer the patient to other pharmacies. (Res. 530, A-99)

D-120.999 Use of Opioids in Chronic Noncancer Pain

(1) Further controlled trials be conducted on opioid therapy in patients with chronic noncancer pain in an effort to identify best practice with regard to selection of both medication and treatment regimens identify patient characteristics that predict opioid responsiveness provide support for guidelines on appropriate precautions, contraindications, and the degree of monitoring required in such patients.

(2) Our AMA encourage states to create multidisciplinary task forces or pain commissions to study the barriers to pain management in their state, and to make and implement recommendations for policy that will create a practice environment conducive to effective pain management. Guidelines promulgated by medical boards are preferable to regulation or statutes.

(3) Our AMA and relevant specialty societies promote educational offerings for physicians to facilitate learning about principles of pain diagnosis and treatment.

(4) Our AMA encourage that appropriate education in pain evaluation and management be provided as an integral part of the core curriculum at all medical schools. (CSA Rep. 11, A-99)

D-125.000 Drugs: Substitution
(See also: Drugs; Drugs: Advertising; Drugs: Cost; Drugs: Labeling and Packaging; Drugs: Prescribing and Dispensing)

D-125.989 Substitution of Biosimilar Medicines and Related Medical Products

Our AMA will: (1) monitor legislative and regulatory proposals to establish a pathway to approve follow-on biological products and

analyze these proposals to ensure that physicians retain the authority to select the specific products their patients will receive; and (2) work with the US Food and Drug Administration and other scientific and clinical organizations to ensure that any legislation that establishes an approval pathway for follow-on biological products prohibits the automatic substitution of biosimilar medicines without the consent of the patient's treating physician. (Res. 918, I-08)

D-125.990 Generic Substitution of Narrow Therapeutic Index Drugs

Our AMA will inform the Centers for Medicare and Medicaid Services, America's Health Insurance Plans, the Pharmaceutical Care Management Association, the National Association of Boards of Pharmacy, the National Association of Chain Drug Stores, the National Community Pharmacists Association, and the American Pharmacists Association about AMA Policies H-125.984 and H-115.974, and will urge these payer and pharmacy organizations to support these AMA policies. (CSAPH Rep. 2, A-07)

D-125.991 Generic Drug Bioequivalence

Our AMA will (1) urge the Food and Drug Administration (FDA) to reexamine its bioequivalence standards regarding levothyroxine; and (2) contact the FDA and request that it reinstate the warning labels for thyroxine manufacturers regarding dose retitration after switching brands. (Res. 721, I-05)

D-125.992 Opposition to Prescription Prior Approval

Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08)

D-125.993 Medicare Part D Guidelines

Our AMA will continue to advocate to CMS, and if appropriate, to the United States Pharmacopeia, our AMA's Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) with respect to drug categories and classes to be covered under Medicare Part D. (Sub. Res. 916, I-04; Reaffirmation A-06)

D-125.994 Impact of Drug Formularies and Therapeutic Interchange on Health Outcomes

Our AMA encourages the Agency for Healthcare Research and Quality and other appropriate public and private organizations to fund or conduct research that assesses the impact of restrictive (closed) or incentive-based drug formularies and the practice of therapeutic interchange on health outcomes. (CSA Rep. 2, A-04)

D-125.995 Health Plan Coverage of Prescription Drugs

In consultation with pharmacy benefit managers (PBMs), public and private sector payers, as well as other appropriate entities, our AMA will continue to pursue the development of model procedures for prescribing non-formulary prescription drugs and promote these procedures to PBMs, public and private sector payers, as well as other appropriate entities. (CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmation A-08)

D-125.996 Regulation of Pharmacy Benefit Manager Contracts

Our AMA, in conjunction with state medical associations, will develop legislation and/or regulatory language to: (1) increase the transparency of the business practices of pharmacy benefit managers (PBMs) with drug manufacturers, health plans, employers, and physicians to minimize conflicts of interest; and (2) to require pharmacy benefit managers to provide information to allow health plans, employers, and physicians to verify if they have met their contractual obligations. (Res. 533, A-03; Reaffirmation A-04)

D-125.997 Interference in the Practice of Medicine

Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others. (Res. 529, A-02)

D-125.998 Health Plan Drug Formularies and Legislation

Our AMA will: (1) continues to work as part of a coalition to develop principles for drug formulary systems that are consistent with AMA policy (H-125.991 and H-285.965); and (2) defer a decision on the development of a national formulary. (BOT Rep. 7, I-99)

D-125.999 Health Plan Coverage for Over-the-Counter Drugs

Our AMA, consistent with Policy H-125.990, continue to support over-the-counter drug benefits under Medicaid that provide

physician-prescribed medications to enrollees. (CMS Rep. 1, I-98; Reaffirmed: CMS Rep. 4, A-08)

D-130.000 Emergency Medical Services

D-130.969 Access to Psychiatric Beds and Impact on Emergency Medicine

As a follow-up to the 2008 American College of Emergency Physicians Task Force Report on Boarding, our AMA will report back to the HOD at the 2009 Annual Meeting with a progress report on the effectiveness of measures implemented to mitigate boarding and crowding in the emergency department. (CMS Rep. 2, A-08)

D-130.970 Development of Bridge Income Strategies for Physicians Impacted by Officially Declared Disasters

Our AMA will evaluate strategies to create or support federal legislation and/or regulations which would provide bridge financial support to physicians following officially declared disasters to ensure an adequate supply of physicians to treat the population of the recovering areas. (Res. 918, I-06)

D-130.971 The Future of Emergency and Trauma Care

Our AMA will:
(1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care;
(2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties;
(3) continue to advocate for the following:
a. Insurer payment to physicians who have delivered EMTALA-mandated,
emergency care, regardless of in-network or out-of-network patient status,
b. Financial support for providing EMTALA-mandated care to uninsured patients,
c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service,
d. Federal and state liability protections for physicians providing EMTALA-mandated care;
(4) report on progress in addressing these issues to the AMA House of Delegates at the 2007 Interim Meeting; and
(5) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation. (BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmation A-08)

D-130.972 All Hazards Disaster Preparedness and Response

Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster. (Res. 426, A-06)

D-130.973 Physician Identification in Emergencies

Our AMA will: (1) advocate for a uniform state physician ID for identification when responding to disasters; (2) work with appropriate agencies to identify mechanisms that would allow physicians to render care during disasters in states where they are not currently licensed and report back to the House at the 2006 Interim Meeting; (3) study and report to the House of Delegates on the issue of possible protection from accusations of civil or criminal liability arising from care rendered to patients during officially declared local, state, or national disasters. (Res. 615, A-06; Res. 610, I-06)

D-130.974 Emergency Preparedness

Our AMA will:

(1) call for each state and local public health jurisdiction to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the Public Health Service, the Department of Health and Human Services, the Department of Homeland Security and other appropriate federal agencies;

(2) continually refine and more actively advocate its three courses, Core, Basic and Advanced Disaster Life Support, and other equivalent courses for training hospital medical and nursing staffs and public health physicians and nurses so they are better prepared to handle mass casualty situations;

(3) work with and through the Federation of State Medical Boards, its member boards and state, district and territorial governments to implement a clearinghouse for volunteer physicians (MDs and DOs) that would validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared;

(4) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency; and

(5) report back at the 2006 Annual Meeting with an update on AMA disaster relief activities. (Sub. Res. 803, I-05; Reaffirmation A-06; Reaffirmed: BOT Rep. 2, A-07)

D-130.975 Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services

Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status. (BOT Rep. 2, I-05; Reaffirmation A-07)

D-130.976 Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule

Our AMA will:

(1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations;

(2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing EMTALA mandated services;

(3) initiate additional advocacy strategies to implement H-130.970(5) that states: "All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize and "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer" and report back at the 2005 Interim Meeting;

(4) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them;

(5) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and

(6) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. (CME Rep. 3, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 605, I-08)

D-130.977 Teaching of CPR as a Part of Comprehensive Health Education Programs

Our AMA will encourage the Centers for Disease Control and Prevention to incorporate CPR training for appropriate age levels in their guidelines on comprehensive health education. (Res. 401, A-05)

D-130.978 Collaboration and Coordination During Disaster Relief

Our AMA Board of Trustees will develop a plan to work with other organizations and help coordinate domestic and international donations of physician resources to populations in acute and chronic need and present the plan at the 2005 Interim Meeting. (Res. 604, A-05)

D-130.979 Plan for the Implementation of a National Disaster Life Support (NDLS) Educational Program

Our AMA will: (1) actively pursue the creation of a National Training Network for the National Disaster Life Support (NDLS) program, based at the state level and coordinated through a newly-developed AMA-based NDLS National Program Office; and (2) support the NDLS Program Office at a level that permits the following enhancements to the NDLS program: revision of the NDLS course sequence, including creation of online Core Disaster Life Support and Basic Disaster Life Support courses, creation of a voluntary electronic registry of NDLS-trained individuals, and outreach to other members of the National Disaster Life Support Education Consortium, to encompass individuals from many specialties and disciplines within the Federation. (CME Rep. 11, A-04)

D-130.980 Changes in the Emergency Medical Treatment and Active Labor Act

Our AMA will study the impact that the new EMTALA regulations will have on patient care particularly at academic medical centers and at facilities in less populous regions, and report back to the AMA House of Delegates at the 2005 Annual Meeting. (Res. 234, A-04)

D-130.981 Improving Regional Terrorism and Disaster Preparedness and Response

Our AMA will: (1) call on the Department of Homeland Security and the Department of Health and Human Services to assure a multi-state coordinating capacity that would provide for more effective local, state, and interstate response to terrorist incidents, including planning, mass casualty care, and risk communication efforts;

(2) call on the Department of Health and Human Services and the United States Public Health Service to expand the Medical Reserve Corps, a branch of the Citizen Corps, to include regional and nationwide organization of volunteer health care professionals to provide additional personnel surge capacity in a national level medical response, including organizational requirements, educational and training needs, and credentialing and liability issues;

(3) call on federal and state agencies to develop a common credentialing standard with liability protection mechanisms to rapidly credential health care providers from other states to facilitate a regional or national level response; and

(4) send letters to the President, Secretary of Homeland Security, Secretary of Health and Human Services, Surgeon General, and appropriate members of Congress urging such action. (Res. 820, I-03; Reaffirmation A-06)

D-130.982 EMTALA -- Major Regulatory and Legislative Developments

Our AMA: (1) continue to work wiith the Federal government to implement the EMTALA-related recommendations of the Health and Human Services Advisory Committee on Regulatory Reform;

(2) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject;

(3) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services;

(4) request that HHS establish a public/private EMTALA Technical Advisory Group which could provide expertise and assistance to the HHS Secretary with respect to the EMTALA rules and interpretative guidelines and their application to hospitals and physicians until the problems of emergency care have been adequately addressed and resolved;

(5) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations.

(6) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply. (BOT Rep. 17, I-02; Reaffirmation A-07)

D-130.983 Notification of Staffed Hospital Bed Shortages

Our AMA join with the American Hospital Association in urging the Department of Homeland Security, Department of Health and Human Services, and other appropriate federal agencies to:

(1) assess the ability of the nation’s hospitals to respond to a mass casualty emergency or bioterrorist attack;
(2) develop a comprehensive strategy to assure adequate surge capacity to address mass casualty care; and
(3) institute ongoing monitoring of surge capacity and sharing of information with appropriate local, state, and federal agencies.

Our AMA shall provide a progress report to the House of Delegates at the 2003 Interim Meeting regarding strategies to address the issue of surge capacity to address mass casualty care. (BOT Rep. 3, I-02)

D-130.984 Payment for Emergency Services

(1) Our AMA shall investigate and explore creative sources and options for new, expanded, and a non-traditional source of funding necessary to support day to day delivery and all emergency health services for report back A-03. (2) Such emergency health services shall be defined to mean the full spectrum of access and capacity, including but not limited to: primary and specialty care access, on call services, intensive care capacity, EMTALA related requirements, trauma care and bioterrorism preparedness. (Sub. Res. 204, A-02; Reaffirmation A-07)

D-130.986 Physician Involvement in Disaster Preparedness

Our AMA will urge the JCAHO to promulgate its revised Standard EC.1.4 on disaster preparedness which incorporates medical staff involvement. (Sub. Res. 807, I-01)

D-130.987 AMA Leadership in the Medical Response to Terrorism and Other Disasters

Our AMA will: (1) recommend that a physician with public health training and experience and a strong background in infectious diseases, disaster medicine, or other appropriate medical specialty be appointed to serve in an official capacity to the newly created Federal Office of Homeland Security; and (2) maintain and regularly update a comprehensive Internet-based resource on disaster medicine and emergency response. (BOT Rep. 26, I-01)

D-130.988 Update: Medical Preparedness for Terrorism and Other Disasters

Our AMA will work with: (1) the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction, the Joint Commission on the Accreditation of Healthcare Organizations, and other appropriate parties to promote our policies and recommendations for medical preparedness for terrorism and other disasters; and (2) and through the Federation of Medicine to develop a mechanism for coordinating disaster/terrorism planning and response activities that involve more than one component medical society. (CSA Rep. 4, A-01)

D-130.989 Coverage of Emergency Services

Our AMA: (1) will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition"; (2) will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy; and (3) in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules. (Res. 229, A-01)

D-130.990 Overcrowding and Hospital EMS Diversions

Our AMA will study the issue of overcrowding of emergency departments, EMS diversions, and lack of hospital beds for admissions, propose ways to reduce or eliminate the problem, and help disseminate information to the public in a manner that will gain public understanding and support of this serious national problem. (Res. 108, A-01)

D-130.991 Hospital Emergency Use

Our AMA Board of Trustees, to the fullest extent appropriate, will authorize continued support of federal legislation containing the same provisions as appear in H.R. 904, Access to Emergency Medical Services Act of 1999. (Sub. Res. 706, I-00)

D-130.992 Medical Preparedness for Terrorism and Other Disasters

(1) Our AMA will call for the creation of a public-private entity (including federal, military, and public health content experts) that will collaborate with medical educators and medical specialty societies to: (a) develop audience-specific medical education curricula on disaster medicine and the medical response to terrorism, with a first charge to develop curricula on bioterrorism, and disseminate these to medical students, physicians in training, and physicians in practice; (b) develop information resources on disaster medicine and the medical response to terrorism for civilian physicians and other health care workers; (c) encourage and work with state and specialty societies, the Centers for Disease Control and Prevention, the Office for Emergency Preparedness, the Agency for Healthcare Research and Quality, the pharmaceutical industry, and other appropriate federal, military and private organizations to develop model plans for community medical response to disasters, including terrorism; (d) address the issue of reliable, timely, and adequate reporting of dangerous diseases by community physicians to public health authorities; and (e) our AMA report back to the House of Delegates on the status of this public-private entity as appropriate.

(2) The AMA will encourage the Federation of Medicine to become involved in planning for the medical component of responses to disasters, including terrorism, at levels appropriate to the Federation Component: (a) county/local medical societies and organized medical staffs are encouraged to become involved in local public health and community planning and physician education; (b) state societies are encouraged to become involved in state response planning and physician education; (c) specialty societies are encouraged to take the lead in conducting and encouraging education of their members in essential components of disaster medicine, as well as encouraging their members to participate in local response planning; and (d) all state and local medical societies and medical specialty societies should take a leadership role in planning for and assuring adequate surge capacity in their state and community to respond to mass casualties resulting from a disaster or other public health emergency.

(3) Our AMA will encourage the JCAHO and state licensing authorities to include the evaluation of hospital plans for terrorism and other disasters as part of the periodic accreditation and licensure visits by their representatives. (CSA Rep. 11, I-00; Modified: BOT Rep. 6, I-03)

D-130.993 Confidentiality of Physician Peer Review

(1) Our AMA will study the threat to the physician peer review process created by health care related federal regulation or statute, i.e. the Emergency Medical Treatment and Active Labor Act (EMTALA); and (2) If our AMA determines that Federal regulations or laws (including EMTALA) undermine state protections for the confidentiality of the peer review process, our AMA will take urgent action to establish protections for covering all Federal programs and related regulations for physician peer review. (Res. 219. I-00)

D-130.994 Limit Scope of EMTALA to Original Legislative Intent

(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians;
(b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients;
(c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement.

(2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose.

(3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting. (Sub. Res. 217, I-00)

D-130.995 Organized Medicine's Role in the National Response to Terrorism - Update

Our HOD will consider the CSA report to be submitted at the 2000 Interim Meeting in order to arrive at recommendations on how the AMA, members of the Federation, and other medical stakeholders can enhance community preparedness for, and response, to natural disasters and acts of terrorism. (CSA Rep. 10, A-00)

D-130.996 On-Call Physicians Task Force

Our AMA will: (1)develop model hospital medical staff bylaws that address the responsibilities of physicians providing on-call coverage at individual hospitals;.

(2) develop educational guidelines to further educate medical staff physicians about on-call requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA);

(3) urge all state medical associations and national medical specialty organizations to play a greater role in identifying needs and possible solutions to on-call physician coverage problems; and

(4) serve as a clearinghouse for sharing local solutions that address physician on-call coverage problems. (BOT Rep. 29, A-00)

D-130.997 Reimbursement of On-Call Physicians

Our AMA: (1) CPT Editorial Panel be requested to develop and publish codes with definitions for "physicians on-call services";.

(2) will request that the AMA's Reimbursement Update Committee develop and submit to CMS the relative value of on-call services;

(3) will take appropriate action as needed to advocate and endorse reimbursement for physician on-call services to hospital facilities; and

(4) will take appropriate action as needed to advocate and endorse appropriate reimbursement by hospitals for physician on-call services to hospital facilities when physicians are required to provide these services as a condition of medical staff privileges. (Res. 117, A-00)

D-130.998 On-Call Physicians

Our AMA will establish and participate in a task force with the American Hospital Association, American College of Emergency Physicians, other appropriate medical specialty societies, medical staff representatives and other interested parties to delineate: (a) the responsibilities of those physicians on-call to the emergency department, (b) mechanisms for payment for care provided by an on-call physician to the emergency department, and (c) options for medical staff on-call coverage to ensure appropriate medical care for all emergency department patients in light of EMTALA requirements and that our AMA report back at A-2000 with a status report of the activities of the Task Force. (CMS Rep. 3, I-99)

D-130.999 Organized Medicine's Role in the National Response to Terrorism

Our AMA and the Federation of Medicine will sponsor a planning conference on this topic immediately preceding the Interim 1999 AMA Meeting and invite all interested parties to help develop such plans and strategies, and that the plans developed from these efforts be reported back to the House of Delegates at the Annual 2000 AMA Meeting. (CSA Rep. 4, A-99)

D-135.000 Environmental Health
(See also: Public Health; Radiation and Radiology)

D-135.985 Air Pollution and Public Health

Our AMA: (1) promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states; and (2) will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies. (Res. 408, A-08)

D-135.986 Public Health Hazards Associated with Landscaping Services

Our AMA encourages the Occupational Safety and Health Administration to collaborate with the AMA, other appropriate medical societies, and other pertinent federal agencies to identify and recommend strategies to prevent and reduce the potential public health hazards created by various landscaping services (including lawn-mowing, fertilization, weed, insect & grub control, tree & bush care, debris removal, fence, driveway, rock garden & stone path construction requiring use of saws, and a full spectrum of motorized equipment). (Res. 403, A-08)

D-135.987 Modern Chemicals Policies

Our AMA: (1) will call upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use; and (2) encourages the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures. (Sub. Res. 404, A-08)

D-135.988 Protective NAAQS Standard for Airborne Lead

Our AMA will submit comments during the public comment period on the National Ambient Air Quality Standards (NAAQS) supporting a tightening of the primary NAAQS for lead and specifically request a lead NAAQS no higher than 0.20 µg/m monthly average. (Res. 432, A-08)

D-135.989 Air Quality Standards and Human Health

Our AMA will sign on or endorse comments submitted by the ATS and American Lung Association supporting a tightening of the

NAAQS for ozone to include an ozone NAAQS of 0.060 ppm for the 8-hour standard. (BOT Action in response to referred for decision Res. 416, A-07 and Res. 438, A-07)

D-135.990 Health Hazards Due to Military Exposure to Depleted Uranium

Our AMA (1) encourages the Institute of Medicine (IOM) and other appropriate scientific organizations to study the potential health effects of exposure to depleted uranium from munitions and (2) will monitor the efforts of the IOM and other scientific organizations to study the potential health effects of exposure to depleted uranium from munitions and report back as appropriate. (Res. 412, A-07)

D-135.991 Radioactive/Chemical Waste and Radiation in the Environment

Our AMA will:

(1) advocate for the development of a transparent, comprehensive national policy and plan for the disposition of US Department of Energy (DOE) radioactive and chemical waste;

(2) support independent, comprehensive environmental testing at all nuclear facilities throughout the country and that the results of any testing be made available to the public;

(3) urge the appropriate federal and state agencies to monitor and/or evaluate the health status of residents in the area of leaking nuclear facilities to accurately determine any adverse impact on health status by leakage of radioactive materials, and make public these results; and

(4) support measures that strengthen the coordination and oversight of nuclear facilities. (CSAPH Rep. 5, A-07)

D-135.992 Mercury Pollution

Our AMA :
(1) recognizes that the trading of air pollutants is potentially harmful for vulnerable populations, and that the Clean Air Mercury Rule is inconsistent with our AMA's health-protective approach to air pollution;
(2) encourages state governments to be proactive in protecting citizens from harmful mercury emissions;
(3) encourages reduction in mercury use in manufacturing wherever possible, and recognize that more must be done using available and emerging technology to reduce mercury emissions;
(4) recommends increased vigilance, monitoring and tracking of mercury use and emissions in chlor-alkali facilities that use mercury in manufacturing processes; and
(5) encourages the US government to assume a leadership role in reducing the global mercury burden and work toward promoting binding, health-protective international standards. (CSAPH Rep. 1, I-06)

D-135.993 Contamination of Drinking Water by Pharmaceuticals and Personal Care Products

Our AMA will: (1) request that the Environmental Protection Agency conduct studies to understand better the public health impact of discarded pharmaceuticals and personal care products on the nation's drinking water supplies; and (2) encourage the EPA and other federal agencies to engage relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems. (Res. 403, A-06)

D-135.994 Human Exposure to Polybrominated Diphenyl Ether (PBDE) Fire Retardants

Our AMA will urge appropriate federal agencies to study and evaluate the use of polybrominated diphenyl ether (PBDE) flame retardants and that any substitute retardants for PBDEs in consumer products also be evaluated appropriately, and through the Council on Science and Public Health, continue to monitor this issue and take action if necessary. (Sub. Res. 414, A-05)

D-135.995 Studying the Health Effects of Aerial Herbicide Spraying Under "Plan Colombia"

Our AMA will request the World Medical Association and the World Health Organization to study the health effects of aerial herbicide spraying in the South American country of Colombia and its neighboring countries. (Res. 420, A-04)

D-135.996 Reducing Sources of Diesel Exhaust

Our AMA will:
(1) encourage the US Environmental Protection Agency to finalize the most stringent feasible standards to control pollutant emissions

from both large and small non-road engines including construction equipment, farm equipment, boats and trains;
(2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from existing diesel; and
(3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with new diesel emissions standards promulgated by US EPA. (Res. 428, A-04)

D-135.997 Research into the Environmental Contributors to Disease

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; and (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue. (Res. 402, A-03)

D-135.998 DEHP Use in Neonatal Intensive Care Units

Our AMA will: (1) assist the FDA in communicating its safety assessment on the use of DEHP-containing devices to health care providers and hospitals across the country; (2) urge the FDA to expedite its evaluation of ways to address the potential risks that may be associated with use of DEHP-containing devices in certain procedures, including the availability of medical devices made from alternatives to DEHP-containing PVC plastics, particularly for procedures performed on neonatal patients; and (3) monitor developments in this area, and respond as appropriate. (Sub. Res. 506, I-01)

D-135.999 Building Environmental Health Capacity in State Health Agencies

Our AMA will urge the US Congress to establish and fund a national program at the Centers for Disease Control and Prevention's National Center for Environmental Health to increase the environmental health capabilities of state and local public health agencies. (Sub. Res. 429, A-99)

D-140.000 Ethics
(See also the *Current Opinions* of the AMA Council on Ethical and Judicial Affairs.)

D-140.963 Security Breaches in Electronic Medical Records

Our AMA will study what the physician's role is in informing a patient if he/she has reason to believe that the patient's protected health information has been inappropriately disclosed. (Res. 9, A-08)

D-140.964 Employment Relations

Our AMA Council on Ethical and Judicial Affairs will submit a report on the ethical implications of permitting physicians to be employees of non-physician health care providers whom the physician is charged with supervising. (Res. 5, A-08)

D-140.965 Physician Employment by a Physician Extender

Our AMA will define the ethical boundaries applicable to physicians supervising or collaborating with physician extenders while concurrently employed by the physician extender. (Res. 13,A-08)

D-140.966 Medical Ethical Guidelines for Informed Consent in Investigational Trials

Our AMA Council on Ethical and Judicial Affairs will review the physician investigator's obligation to inform patients of potential conflicts of interest in recommending patients for, or the conduct of, a proposed research study. (Res. 12, A-08)

D-140.967 End of Life and Allow Natural Death

Our AMA will study alternatives to Do Not Resuscitate (DNR) by working with state medical societies and other major stakeholders to conduct a comprehensive review and study of all state Advance Directives to determine whether the state DNR systems and forms should be changed to AND (Allow Natural Death), LET (Limits of Emergency Treatment), POLST (Physician Orders for Life-Sustaining Treatment) or some other alternative systems. (Res. 6, A-08)

D-140.968 Standardized Advance Directives

Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 1993, and work with our state medical societies to advocate for its adoption in the states. (BOT Action in response to referred for decision Res. 220, A-07)

D-140.969 "Secret Shopper" Patients

Our AMA AMA Council on Ethical and Judicial Affairs will study and report back regarding the ethics of such practices as using "secret shopper" patients or other similar practices to evaluate the care that is delivered. (Res. 11, A-07)

D-140.971 Ethical and Legal Issues in Responding to Occupational HIV Exposure

Our AMA Council on Ethical and Judicial Affairs will further examine the ethical issues pertaining to HIV testing. (BOT Rep. 1, A-07)

D-140.972 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations

Our AMA Council on Ethical and Judicial Affairs will consider revising E-8.132 to address all health care delivery settings. (BOT Rep. 38, A-06)

D-140.973 Trademarks, Patents, Copyrights, and Other Legal Restrictions on Medical Procedures

Our AMA Council on Ethical and Judicial Affairs will study and evaluate: (1) whether there is an ethical difference between the use of patents for medical procedures and techniques and the use of such legal devices as trademarks, copyrights, confidentiality agreements and practice agreements for the specific effect of limiting access to new medical procedures and techniques; and (2) whether to affirm Opinion E-9.095 in its present form or to amend Opinion E-9.095 to provide that the use of any legal devices, including patents, trademarks, copyrights, confidentiality agreements and practice agreements, for the purpose of restricting and limiting access to medical procedures and techniques shall be considered unethical. (Res. 1, A-06)

D-140.974 Universal Out-of-Hospital DNR Systems

Council on Ethical and Judicial Affairs' proposed replacement of Opinion E-2.22, "Do Not Resuscitate Orders," will be filed at the 2005 Interim Meeting. (CEJA Rep. 6, A-05)

D-140.975 Ethics of Physician Participation in Reality Television for Entertainment

Our AMA Council on Ethical and Judicial Affairs will evaluate existing opinions on advertising and informed consent and render new opinions as appropriate to guide the participation of professionals in the emerging commercial medical practice of reality television for entertainment. (Res. 607, I-04)

D-140.976 Advance Health Care Directive

Our AMA will:

(1) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD) as soon as reasonably possible;

(2) 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;

(3) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems;

(4) create other strategies to help physicians encourage all their patients to complete their DPAHC/AD;

(5) work with Congress and the Department of Health and Human Services to 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 as soon as reasonably possible; and

(6) advocate for the implementation of secure electronic advance health care directives. (Res. 603, I-04; Reaffirmed: Res. 209, A-05; Reaffirmation A-06; Reaffirmed: BOT Rep. 22, A-06: Appended: Res. 4, A-07; Reaffirmed: BOT Rep. 9, A-08)

D-140.977 Selection of Health Care Decision-Making Surrogates

The Council on Ethical and Judicial Affairs' proposed amendments to Opinion E-8.081, "Surrogate Decision Making," will be filed at I-04. (CEJA Rep. 3, A-04)

D-140.978 Commercial Medical Screening

Considering the summary information in this report, the Council on Ethical and Judicial Affairs will further consider the ethical ramifications of commercialized medical screening. (CSA Rep. 10, A-03)

D-140.979 Moratorium on the Imposition of the Death Penalty

Our American Medical Association will actively disseminate its opinion regarding physician non-participation in legally authorized executions. (Res. 5, A-03)

D-140.980 Pending Federal Executions

Our AMA immediately inquire whether federal executions involve physicians, and if physicians are involved, that our AMA communicate to the federal government that such physician participation violates fundamental ethical standards of the medical profession and that other appropriate means be substituted that do not require physician participation. (Res. 9, A-01)

D-140.981 Ethical Guidelines on Gifts to Physicians from Industry

Our AMA shall: (1) communicate to all medical school deans and residency program directors the importance of including education on ethical guidelines regarding gifts to physicians from industry within the ethics curriculum of their medical student and housestaff education programs; (2) communicate to all medical school deans and residency program directors the content of CEJA Opinion E-8.061 and shall recommend that it or another nationally-recognized ethical guideline be used as the basis for educational content on this issue; and (3) recommend to all medical school deans and residency program directors that appropriate policies be developed for medical students, housestaff and faculty in their respective institutions regarding the issue of gifts to physicians from industry. (Res. 13, A-02; Reaffirmed: Res. 303, A-05)

D-140.982 Physician Participation in Execution

Our AMA shall expand efforts to educate the medical profession regarding this ethic. (Res. 10, A-02)

D-140.983 Restrictive Drug Policies in Public Programs such as Medicaid

(1) Our AMA ask that its Council on Ethical and Judicial Affairs (CEJA) study the ethical implications of restrictive drug formularies and prior authorization requirements in public tax-supported medical assistance programs and prepare an opinion containing the physician's options and responsibilities with respect to these formularies. (2) CEJA's ethical opinions regarding all medication formularies be reexamined in light of the precedent that formularies potentially place patients' interests secondary to cost containment. (Res. 3, A-01)

D-140.984 Support for Pain Control and Research

Our AMA congratulates and commends the American Academy of Pain Medicine on their significant accomplishment in achieving passage of legislation providing for the "Decade of Pain Control and Research." (Sub. Res. 514, I-00)

D-140.985 Patenting of Genes and Their Mutations

Our Council on Scientific Affairs will continue to monitor progress in the area of patenting of Genes and their mutations and report back to the House of Delegates as appropriate. (CSA Rep. 9, I-00)

D-140.986 Use of Anatomical Gifts in Medical Research and Education

Our AMA will study current legal safeguards for proper ethical procurement and use of human tissue for research and education. (Res. 5, I-00; Reaffirmation I-07)

D-140.987 Preservation of National Bioethics Advisory Commission

Our AMA will recommend to Congress and the next Administration that the federal government create and fund a permanent commission whose ethical recommendations would help determine federal policy for biologic issues. (Res. 9, I-00)

D-140.988 National Advance Care Planning Day

Our AMA will: (1) proclaim the day after Thanksgiving annual Advance Care Planning Day; and (2) work with members of the

Federation to create local, state, and national programs to educate professionals and the public about the importance and process of advance care planning. (Res. 6, A-01)

D-140.989 Requesting Consent for Invasive Procedures in the Newly Deceased Patient

Our AMA will study the issue of using deceased patients for training or other educational purposes and develop ethical guidelines regarding this practice. (Res. 1, A-01)

D-140.990 Gene Patents

Our AMA will examine the issues surrounding gene patenting and report to the House of Delegates at the 2000 Interim Meeting. (Sub. Res. 510, A-00)

D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols

Our AMA will remind all state medical societies to review their state execution statutes to ensure that physician participation is not required. (Res. 3, A-00)

D-140.992 Clinical and Professional Impacts of Cost Containment Efforts

Our AMA will study the ethical conflicts of physicians who in the course of their professional activity became aware of decrements in quality and outcomes of care induced by cost containment activities and do not report them. (Res. 714, I-99)

D-140.993 Pharmacy Benefit Risk-Sharing by Physicians

Our AMA will ask the Council on Ethical and Judicial Affairs to consider developing an ethical opinion on pharmacy benefit risk-sharing by physicians. (CMS Rep. 12, I-99)

D-140.994 Use of DNA Testing

Our AMA will: (1) study the conflicts arising between the needs for collecting DNA samples for patient care versus the use of DNA information in the criminal justice system; and (2) report back to the House of Delegates on this issue. (Res. 513, I-99)

D-140.995 Distribution of AMA Code of Ethics

Our AMA will investigate effective, fiscally responsible ways of distributing unannotated copies of the Code of Medical Ethics to first-year medical students including electronic means. (Res. 605, A-99)

D-140.996 Review of Guidelines for Pre-test and Post-test Education and Genetic Counseling by the National Society of Genetic Counselors and Other Organizations

Our AMA will urge adoption by the appropriate medical societies, federal agencies, and third party payers of the National Society of Genetic Counselors guidelines, with the caveat that post-test protocols may differ depending on the nature of the disease and the available therapeutic/curative options. (CSA Rep. 5, A-99)

D-140.997 Professional Courtesy

Our AMA will disseminate the AMA's and CMS's current positions regarding professional courtesy to the physicians in this country. (Res. 6, A-99; Reaffirmed: CEJA Rep. 2, A-04)

D-140.999 Preservation of Professional Courtesy

Our AMA will petition CMS, the U.S. Attorney General and the U.S. Congress to reverse the unreasonable and intrusive policy of considering professional courtesy among physicians fraud. (Res. 6, I-98; Reaffirmed: CEJA Rep. 2, A-04)

D-145.000 Firearms: Safety and Regulation

D-145.998 Reauthorization and Strengthening of the 1994 Assault Weapons Ban

Our AMA will: (1) advocate for the renewal of the 1994 federal Assault Weapons Ban;

(2) advocate for a strengthening of the ban on assault weapons to better regulate civilian transfer and possession by:

(a) Clarifying the definition of an assault weapon to help prevent gun makers and sellers from evading the ban;
(b) Banning conversion parts kits;
(c) Regulating "grandfathered" assault weapons;
(d) Enhanced tracing of such weapons;
(e) Banning all high-capacity magazines, including imports; and
(f) Prohibiting juvenile possession; and

(3) send a letter to the President, Attorney General, Surgeon General, and appropriate members of Congress indicating this strong support. (Res. 911, I-03)

D-145.999 Epidemiology of Firearm Injuries

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms; (3) assist in convening a broad-based coalition to thoroughly examine the issue of gun-related violence from a public heath perspective; and (4) present a report of these activities to the House of Delegates at the 2003 Interim Meeting. (Res. 424, A-03)

D-150.000 Foods and Nutrition

D-150.980 Appropriate Supplementation of Vitamin D

Our AMA urges the Food and Nutrition Board of the Institute of Medicine to re-examine the Daily Reference Intake Values for Vitamin D in light of new scientific findings. (Res. 425, A-08)

D-150.981 The Health Effects of High Fructose Syrup

Our AMA:

(1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS;

(2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response; and

(3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet. (CSAPH Rep. 3, A-08)

D-150.982 Fresh Meat Color Preserving

Our AMA will seek federal regulations to require that any meat sold in the United States that is treated and/or packaged in such a way to retain a fresh red appearance be conspicuously labeled on the front of the package to state: “this meat has been packaged in such a way to maintain a fresh red appearance.” (Res. 424, A-07)

D-150.983 Food Stamp Incentive Program

Our AMA supports legislation to provide a meaningful increase in the value of food stamps when used to purchase fruits and vegetables. (Res. 405, A-07)

D-150.984 Eating Disorders and Promotion of Healthy Body Image

1. Council on Science and Public Health Report 8-A-07, Eating Disorders and Promotion of Healthy Body Image, will be widely disseminated to assist primary care physicians and other health care professionals in the early recognition and treatment of eating disorders.

2. Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image. (CSAPH Rep. 8, A-07)

D-150.985 Folic Acid Fortification of Grain Products

Our AMA will: (1) urge the Food and Drug Administration to recommend folic acid fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label; and (2) write letters to domestic and international producers of corn grain products, including masa, nixtamal, maize, and pozole, to advocate for folic acid fortification of such products. (CSAPH Rep. 6, A-06)

D-150.986 Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake

Our AMA will:

(1) Call for a stepwise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.
(2) Urge the Food and Drug Administration (FDA) to revoke the "generally recognized as safe" (GRAS) status of salt, and to develop regulatory measures to limit sodium in processed and restaurant foods.
(3) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake.
(4) Discuss with the FDA ways to improve labeling to assist consumers in understanding the amount of sodium contained in processed food products, and to develop label markings and warnings for foods high in sodium.
(5) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods. (CSAPH Rep. 10, A-06)

D-150.987 Addition of Alternatives to Soft Drinks in Schools

Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools. (Res. 413, A-05; Reaffirmation A-07)

D-150.988 Revision of Nutrition Labels

Our AMA will ask the appropriate federal agency or body to require that the nutritional labels on all products sold in the United States have both the absolute amount (in appropriate units) and the percent daily values listed for the nutrients in the product. (Res. 428, A-05)

D-150.989 Healthy Food in Hospitals

Our AMA will urge (1) component medical societies, member physicians and other appropriate local groups to encourage palatable, health-promoting foods in hospitals and other health care facilities and oppose the sale of unhealthy food with inadequate nutritional value or excessive caloric content as part of a comprehensive effort to reduce obesity; and (2) health care facilities that contract with outside food vendors to select vendors that share their commitment to the health of their patients and community. (Res. 420, A-05)

D-150.990 Chronic Wasting Disease: Implications for Human Health

Our AMA will:

(1) urge the Food and Drug Administration to (a) continue aggressive enforcement of existing regulations to prevent the transmission of animal-transmissible spongiform encephalopathies to humans, and (b) consider making Draft Guidance Document 158, *Use of Material From Deer and Elk in Animal Feed*, into a regulation;

(2) encourage continued research into the potential transmission of chronic wasting disease (CWD) to other animals and humans; and

(3) support continued surveillance of the CWD epidemic in cervids and continued investigation into human cases of Creutzfeldt-Jakob disease that appear to have an epidemiological link to exposure to CWD. (CSA Rep. 3, A-05)

D-150.991 Herbal Products and Drug Interactions

Our AMA will: (1) support the Food and Drug Administration’s efforts to create a publicly accessible database of adverse event and drug interaction information on dietary supplements; and (2) renew efforts to accomplish the objectives of Policy H-150.954,

particularly with respect to the labeling requirements for dietary supplements. (Sub. Res. 518, A-04)

D-150.992 Labeling of Nitrite Content of Processed Foods

Our AMA will support the current Food and Drug Administration and United States Department of Agriculture regulations, including current labeling requirements, for nitrites in food, and will encourage continued research and surveillance of the safety of nitrite use in foods, with particular attention to its possible effects on type 1 diabetes. (CSA Rep. 9, A-04)

D-150.993 Obesity and Culturally Competent Dietary and Nutritional Guidelines

Our AMA and its Minority Affairs Consortium will study and recommend improvements to the US Department of Agriculture's Dietary Guidelines for Americans and Food Guide Pyramid so these resources fully incorporate cultural and socioeconomic considerations as well as racial and ethnic health disparity information in order to reduce obesity rates in the minority community, and report its findings and recommendations to the AMA House of Delegates by the 2004 Annual Meeting. (Res. 428, A-03)

D-150.994 Sympathomimetic Amine-Based Products

Our AMA will: (1) recommend that the Food and Drug Administration and other appropriate governmental agencies evaluate the potential adverse effects of over-the-counter (OTC) sympathomimetic amines, such as pseudoephedrine, to determine if they cause harmful cardiovascular effects (eg, stroke, hypertension) that would warrant reconsideration of their OTC status; and (2) work toward educating physicians and the public about the potential adverse effects associated with the use of dietary supplements containing sympathomimetic amines. (Substitute Res. 525, A-03)

D-150.995 Dietary Supplement and Health Education Act

Our AMA will renew its effort to revise the Dietary Supplement and Health Education Act in accordance with Policy H-150.954. (CSA Rep. 9; A-03)

D-150.996 Irradiation of Foods in the United States

Our AMA will urge that the US Department of Agriculture implement irradiation of appropriate foods in the United States prior to its distribution to the public. (Res. 502, I-01)

D-150.997 Purity, Accuracy, Identification and Labeling of Dietary Supplement Ingredients

Our AMA will urge the FDA to expedite the promulgation of regulations on good manufacturing processes for dietary supplements. (Sub. Res. 516, I-00)

D-150.998 Genetically Modified Foods

Our AMA will study the issue of genetically modified foods and issue a report back to the House of Delegates. (Res. 512, I-99)

D-155.000 Health Care Costs
(See also: Drugs: Cost; Health Care Delivery; Health Care Reform; Managed Care)

D-155.992 Appropriate Hospital Charges

Our AMA will: (1) study the consequences of hospital cost-shifting upon individuals who are not covered by large purchasers of health care and report the suggested remedy; and (2) work with the American Hospital Association to develop a transparent pricing system, develop patient education information explaining individual hospital billing processes and discounts available, and educate patients on their bill-paying rights and responsibilities. (Res. 706, A-08)

D-155.993 Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios

Our AMA:
(1) will develop model state legislation and regulations that would require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs, using the format called for in AMA Policy H 155.963;
(2) supports state legislation to require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs; and
(3) supports the development and implementation of a uniform, national accounting and reporting system to report administrative expenses and medical expense ratios as part of greater, national uniformity of market regulation. (Res. 727, A-08)

D-155.994 Value-Based Decision-Making in the Health Care System

1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.

2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress. (CMS Rep. 7, A-08)

D-155.995 Containing Catastrophic Care Costs

Our AMA will:

(1) in order to ensure that quality of care is not compromised, encourage physicians and the medical profession to become more engaged in the development and implementation of cost-containment policies and strategies, particularly those directed toward high-cost patients;

(2) support additional research into the characteristics of the five percent of the patient population with the highest health care costs;

(3) support greater evaluation of the use of disease management, case management, pay-for-performance, and end-of-life care programs for high-cost patients, so that their cost-containment impact and projected future savings can be better assessed; and

(4) continue to inform the medical profession and the general public regarding issues impacting catastrophic care costs and the complexities therein. (CMS Rep. 5, A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06

D-155.996 Health System Expenditures

Our AMA will work to improve our health care system by:

(1) researching and collating existing studies on how health care dollars are currently spent;

(2) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and

(3) disseminating these findings to the American public, US Congress, and appropriate agencies. (Res. 103, A-05)

D-155.997 Containing Catastrophic Care Costs

Our AMA will gather together all relevant information concerning the most expensive 5% of the medical patients in order to be able to devise ways to handle these cases less expensively by: using best-management practices, exploring whether "centers of excellence" provide catastrophic care more efficiently, exploring whether consultation from regional or national experts at an earlier time in these high cost cases might provide benefit, earlier consideration of end-of-life issues, and better education about "palliative" medicine. (Res. 716, A-04)

D-155.998 Meeting with Business Coalitions

Our AMA: (1) shall continue to monitor the activities of business coalitions and other health care coalitions, including The Leapfrog Group, and keep physicians and the Federation of Medicine informed of the activities and new initiatives of these coalitions;

(2) shall continue to meet with and serve with vigilance on appropriate advisory committees to national business and other health care coalitions, including The Leapfrog Group, to establish a dialogue with these coalitions and provide physicians' unique clinical and patient-centered expertise in a manner consistent with AMA policy and sound quality and patient safety principles;

(3) shall encourage the other members of the Federation of Medicine to meet with and serve on appropriate advisory committees to business and other health care coalitions in their geographic area or field of medical specialization to establish a dialogue with these coalitions and provide physicians' unique clinical and patient-centered expertise in a manner consistent with sound quality and patient safety principles and keep the AMA informed of the results of these activities;

(4) continue to promote its policies regarding the proper collection and use of physician and hospital quality data;

(5) shall advocate that business and health care coalitions, and other similar entities be reminded that the JCAHO standards, as well as most state hospital licensure laws, require that the advice and approval of the hospital medical staff or medical groups must be sought before clinical practices are modified;

(6) shall actively address with business and health care coalitions, as well as with other similar entities, the problems of delivering quality care that are created by under-reimbursement of health care services by third party payers; and

(7) shall exercise extreme caution when meeting with The Leapfrog Group and other business coalitions to avoid implied and unintended concurrence with the recommendations of such groups. (BOT Rep. 22, A-02)

D-155.999 Energy Efficiency and Medical Practice

Our AMA will urge its individual members and organizational affiliates to participate in energy efficiency activities in all medical facilities including hospitals, clinics, offices and research facilities. (Res. 413, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

D-160.000 Health Care Delivery
(See also: Health Care Reform; Health Insurance; Health Maintenance Organizations; Preferred Provider Arrangements)

D-160.941 Rescind the Rule Signing of Verbal Orders within 48 Hours

Our AMA will report back to the House of Delegates on the progress made in rescinding the 48 hour rule. (Sub. Res. 844, I-08)

D-160.942 Principles of the Patient-Centered Medical Home

Our AMA will continue to study the patient-centered medical home concept, with particular emphasis on funding sources and payment structures. (Res. 804, I-08)

D-160.943 Ambulatory Surgical Centers

Our AMA will: (1) review economic data regarding the comparative effectiveness of ambulatory surgical centers (ASCs); and (2) advocate for federal and state legislative solutions that would remove barriers, including Certification Of Need (CON) laws, that impair the ability of physicians to build, own and practice in ASCs. (Res. 207, A-08)

D-160.944 Recognizing Transitions of Care for Performance Improvement

Our AMA will:

(1) work to improve and standardize the flow of critical information across the spectrum of care through collaboration with long-term care stakeholders, including the American Medical Directors Association (AMDA);

(2) work with other stakeholder organizations including the AMDA in an effort to develop standardized transfer forms and to promote educational initiatives that optimize transfer of information across the spectrum of care;

(3) work with the Physician Consortium for Performance Improvement to develop specific measures appropriate for recognizing the work effort that assure transitions of care across the continuum of care to be safe, patient centered and outcome driven; and

(4) work with other stakeholder organizations including the AMDA to develop educational initiatives and long-range projects to optimize the transfer of information across the spectrum of acute and long-term care. (Res. 702, A-08)

D-160.945 Communication Between Hospitals and Primary Care Referring Physicians

Our AMA:

(1) advocates for continued Physician Consortium for Performance Improvement® (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings;

(2) advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety;

(3) will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process; and

(4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality. (BOT Rep. 1, A-08)

D-160.946 Eliminating the Barriers to Surviving Acute Miocardial Infarction

Our AMA will: (1) work with relevant societies to conduct a thorough analysis of the geographic, economic and political barriers to optimal care for the ST-elevation myocardial infarction (STEMI) patient, e.g., the current environment, existing literature, the costs of ambulance ECG hardware, training and transmission; political issues of reimbursing one county for care provided to patients from another county or state, and the financial issues of shifting patients to centers that can perform preferred treatment algorithms; and (2) develop model legislation that would draw upon the successes of existing programs and the data garnered from a comprehensive environmental analysis, to identify workable solutions to breaking down the geographic, economic and political barriers to optimal care for the STEMI patient that currently exist. (Res. 529, A-08)

D-160.979 Health Care Disparities in Same-Sex Partner Households

Our AMA will evaluate existing data concerning same-sex couples and their dependent children and report back to the House of Delegates to determine whether there is evidence of health care disparities for these couples and children because of their exclusion from civil marriage. (Res. 522, A-08)

D-160.980 Elimination of the 48-Hour Signature Rule

Our AMA will request, from the appropriate agencies of the federal government, data that supports the mandate that verbal orders from a physician be signed within 48 hours of their issue; and in the absence of adequate supporting data, our AMA shall request that this requirement be rescinded and publicize in the professional and lay press our request and its rationale. (Res. 503, A-08; Reaffirmed: Sub. Res. 844, I-08)

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; and (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. (Res. 321, A-08)

D-160.982 Removing Patient Translation and Interpretation Costs From Physician Responsibility

Our AMA will provide an update to its membership on the progress it has made on eliminating the requirement that physicians pay for translation and interpretation services for patients, an analysis of the implications of current regulatory activity on this issue, and plans for addressing this problem. (Res. 103, A-08)

D-160.983 AMA Support of Free Clinics for the Uninsured

Our AMA will study free clinics with the goal of facilitating improved access to care for the uninsured, consistent with the message of our AMA "Voice for the Uninsured" campaign. (Res. 112 , A-08)

D-160.984 CMS Rule 4105F: Notification of Hospital Discharge Appeal Rights

Our AMA will monitor the implementation of CMS Rule 4105F: Notification of Hospital Discharge Appeal Rights (the Rule) in order to ascertain: (1) whether the Rule requirements that went into effect on July 1st of this year actually impose a significant fiscal strain on the health care delivery system and on hospitals with overcrowding; and, (2) the appropriate level of assistance, if any, to provide to the American Hospital Association (AHA) advocacy efforts on this issue. (BOT Action in response to referred for decision Res. 729, A-07)

D-160.985 Establishment of a Federal Office of Men's Health

Our AMA encourages the establishment of an Office of Men's Health at the U.S. Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health. (Res. 417, A-07)

D-160.986 The Alliance of Retail Clinics with Pharmaceutical Chains

Our AMA will:
(1) ask the appropriate state and federal agencies to investigate ventures between retail clinics and pharmacy chains with an emphasis on the inherent conflicts of interest in such relationships, patients' welfare and risk, and professional liability concerns;
(2) continue to work with interested state and specialty societies in developing guidelines for model legislation that regulates the operation of store-based health clinics; and
(3) oppose waiving any state and/or federal regulations for store-based health clinics that do not comply with existing standards of medical practice facilities. (Sub. Res. 705, A-07)

D-160.987 48-Hour Signature Rule

Our AMA (1) will work with the American Hospital Association to oppose any federal requirement imposed on physicians which requires a signature within 48-hours for verbal or phone orders and (2) will develop model state legislation that would supersede and eliminate the federal requirement for the signature of verbal or phone orders within 48 hours. (Res. 529, A-07; Reaffirmed: Sub. Res. 844, I-08)

D-160.988 Financial Impact of Immigration on American Health System

Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid. (Res. 235, A-06)

D-160.989 Physician-to-Physician Communication

Our AMA will: (1) study and report back to the House of Delegates with recommendations for action on how to improve communication between physicians and among health systems as patients transition from one health care setting to another, and that these recommendations may include:
(a) Definition of the basic package of information to be included with a transfer;
(b) Lists of tests completed, but results pending, including how these results may be accessed;
(c) Lists of tests and procedures planned, but not completed, including who, when and where such tests and procedures shall be done;
(d) Name, specialty and telephone number of each physician caring for the patient;
(e) Preparation of a discharge summary at the time of transfer, explaining the outcomes of the presenting complaints;
(f) Outpatient consultation forms detailing the reasons a specialty consultation has been requested;
(g) Means of transmitting information, including written and electronic formats; and
(h) Identification of who may be notified should communication fail; and
(2) work with other interested organizations to improve physician-to-physician communications. (Res. 725, A-04)

D-160.990 Identification of Health Care Providers

Our AMA will encourage all medical facilities to provide reliable identification of health care providers. (Res. 704, A-04)

D-160.991 Licensure and Liability for Senior Physician Volunteers

Our AMA (1) and its Senior Physician Group will inform physicians about federal and state-based charitable immunity laws that protect physicians wishing to volunteer their services in free medical clinics and other venues; and (2) will work with organizations representing free clinics to promote opportunities for physicians who wish to volunteer. (BOT Rep. 17, A-04)

D-160.992 Appropriate Reimbursement for Language Interpretive Services

Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English. (Res. 209, A-03)

D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists

Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia

services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals. (Res. 220, I-01)

D-160.994 Increased Incidence of Childhood Asthma

Our AMA BOT through the Council on Scientific Affairs will: (1) prepare a report reviewing the scientific literature concerning the increased incidence of childhood asthma, including the relationship between asthma and socioeconomic status, psychosocial factors, air pollution and exposure to environmental toxins; and (2) develop recommendations, based on the scientific literature, for specific public policy, public education and/or legislation designed to reduce the incidence of childhood asthma. (Res. 412, A-01)

D-160.995 Physician and Nonphysician Licensure and Scope of Practice

Our AMA will: (1) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority;

(2) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care;

(3) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups; and

(4) encourage the Association of American Medical Colleges to undertake a study of medical practice in a multidisciplinary environment and the educational infrastructure and processes necessary to ensure the preparation of physicians (MDs and DOs) for such practice using the expertise of the Council on Medical Education and the Council on Medical Service and report back at the June 2002 meeting of the House of Delegates. (CME Rep. 1, I-00)

D-160.996 Low Literacy as a Barrier to Healthcare

Our AMA will commend the ongoing activities of the AMA Foundation to address health literacy as a major program effort over the next few years. (Res. 415, I-99)

D-160.997 Aetna /US Health Care-Prudential Merger

Our AMA will secure intervention by the Department of Justice to stop the Aetna/US Healthcare merger with Prudential Insurance. (Res. 212, A-99)

D-160.999 Opposition to Criminalizing Health Care Decisions

Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making." (Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08)

D-165.000 Health System Reform
(See also: Health Care Costs; Health Care Delivery; Health Insurance)

D-165.945 Study Effects of Individual Health Insurance Mandates

Our AMA will conduct a study of the effects of the Massachusetts individual health insurance mandate on individuals, taxpayers and physicians for report back to the House of Delegates by the 2009 Annual Meeting. The report shall include details on the number of uninsured remaining, public financing required, effect on private health insurance, primary care physician availability, physician reimbursement, and physician public reporting and compliance requirements. (Res. 808, I-08)

D-165.946 Presidential Candidates' Views on Health System Reform

Our AMA will use its communications vehicles such as AMNews, AMA Voice and the AMA Web site, to publicize the health care positions of the major US Presidential candidates and encourage physicians to become more informed voters. (BOT Action in response to referred for decision Res. 603, I-07)

D-165.947 Standardizing AMA Policy on the Tax Treatment of Health Insurance

Our AMA will study and report back at the 2008 Interim Meeting the effect of changing the tax system from the deductibility of

healthcare "expenses" to the deductibility of "insurance premiums" on self-insured employers. (CMS Rep. 8, A-08)

D-165.948 Standardizing AMA Policy on the Tax Treatment of Health Insurance

Our AMA will study the tax treatment of health savings account contributions, earnings and withdrawals, both currently and upon enactment of legislation to replace the existing employee income tax exclusion for employer-sponsored health insurance with tax credits for individuals and families, as referenced in AMA Policy H-165.852[2]. (CMS Rep. 8, A-08)

D-165.949 Assessing the Health Care Proposals of the US Presidential Candidates

1. A new section on the AMA Web site will be created that will enable site visitors to review and evaluate the details of the health system reform proposals of declared presidential candidates by providing (a) links to the web sites of the candidates, and (b) a checklist of the AMA's key strategic priorities.
2. Our AMA will explore developing questions based on the AMA health care reform plan that could be sent to declared presidential candidates requesting their responses and that the responses be included verbatim on the AMA website. (BOT Action in response to referred for decision Res. 115, A-07 and Res. 139, A-07)

D-165.950 Educating the American People About Health System Reform

Our AMA will: (1) distribute our policy positions on health system reform to all declared candidates for the presidency of the United States of America and formally request their public support of those positions; and (2) undertake a media campaign designed to educate the American people about AMA policy on health system reform, emphasizing pluralism, individual ownership of health insurance and the insurance market reforms necessary to allow free market principles to function. (Res. 717, I-07)

D-165.951 Participation in Citizens' Health Care Working Group

Our AMA will continue to monitor the Working Group's progress, but will remain focused on advocating the AMA proposal for expanding health insurance coverage and choice through our active participation in other coalition activities, such as the Health Care Coverage for the Uninsured (HCCU) consensus-building process. (BOT Action in response to referred for decision Res. 107, A-06)

D-165.952 National Health Care Policy Agenda

1. Our AMA will synthesize current AMA policy for the specific purpose of advocating a comprehensive, patient-centered National Health Care Policy Agenda.

2. This Agenda will strongly address the most important issues affecting physicians and patients in the United States, such as public- and private-sector financing and delivery, care for the uninsured, wellness and personal responsibility, liability, patient safety, and health information technology, and recommend comprehensive and workable solutions.

3. Our AMA will develop an appropriate mechanism to present a draft of the National Health Care Policy Agenda to members of the House of Delegates at the earliest opportunity prior to the 2007 Annual Meeting to allow delegates an appropriate period of time to review and offer feedback prior to the 2007 Annual Meeting.

4. A forum on the National Health Care Policy Agenda will be held at the 2007 Annual Meeting to debate and offer feedback to the Board of Trustees.

5. Once finalized, our AMA will use the National Health Care Policy Agenda as a framework for discussion with leaders of United States medicine, business, health care, employers, and government.

6. Our AMA will present the National Health Care Policy Agenda to the President of the United States, the Congress, the American people, and the major political parties by August 31, 2007, so that it can appropriately frame and drive the health care policy debate in the 2008 presidential election. (Res. 607, I-06)

D-165.953 Crisis Commission on the State of Health Care in America

Our AMA will continue to place a high priority on advocacy and coalition-building activities to expand health insurance coverage to the uninsured, and continue its active participation as a member of the Search for Common Ground/Health Care Coverage for the Uninsured. (BOT Action in response to referred for decision Res. 114, A-05; Reaffirmation I-07)

D-165.954 Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans

Our AMA will:

(1) educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care;

(2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings; and

(3) support the North Carolina Medical Society proposal to pilot test individual medical accounts (IMAs). (CMS Rep. 3, I-05)

D-165.955 Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured

1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all.

2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region. (CMS Rep. 1, I-05)

D-165.956 Guam's Gross Receipts Tax Discriminates Against Physicians

Our AMA (1) opposes any tax that discriminates against physicians and their practices because of the adverse impact upon quality care and access to care; and (2) supports the passage of legislation in Guam opposing physician taxes, so that Guam may continue to retain and recruit physicians and continue to have open access to patients and an incentive to enhance the quality of care to patients. (Res. 101, A-05)

D-165.957 State Options to Improve Coverage for the Poor

Our AMA (1) urges national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons; and (2) encourages state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage. (CMS Rep. 1, A-05)

D-165.958 Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits

Our AMA will: (1) continue work to create and fund programming that will educate both physicians and patients about our AMA plan for insurance reform and publicize that plan to the general public; (2) continue to study Health Savings Accounts in order to gain more insight into their effects on a large scale and to determine if our AMA could use them as another means of increasing health care access in our nation; and (3) study other mechanisms beyond tax credits for covering America’s uninsured, and report back at the 2005 Interim Meeting. (Res. 703, I-04)

D-165.959 State-Based Demonstration Projects to Expand Health Coverage to the Uninsured

Our AMA will urge enactment of federal legislation to authorize and fund state-based demonstration projects, including, but not limited to, implementing refundable, advanceable tax credits inversely related to income in the 109th Congress. (BOT Rep. 13, I-04; Modified: CMS Rep. 8, A-08)

D-165.960 Promoting a National Health Care Forum

Our AMA will:

(1) continue to place a high priority on advocacy and coalition-building activities to expand health insurance coverage to the uninsured;

(2) include a session on health system reform as part of its 2005 National Advocacy Conference in Washington, DC, and invite representatives of the Centers for Medicare and Medicaid Services, insurance industry, business community, legal community, hospitals, and nursing homes, as well as consumers and others determined by our Board of Trustees that have a significant interest in access and financing of health care to participate in the session; and

(3) publicize the results of the 2005 National Advocacy Conference session on health system reform to the participants and other interested parties. (BOT Rep. 12, I-04)

D-165.961 Physician Taxes

Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities. (Res. 728, I-04; Reaffirmation A-05)

D-165.962 Health Savings Accounts for Older Americans

Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals. (Sub. Res. 702, A-04)

D-165.963 Health Savings Accounts

The AMA will: (1) strongly encourage employers to consider offering Health Savings Accounts as an option for their employees; and (2) will continue to examine alternative means for the financing of health care consistent with AMA policy and sound principles of medical practice. (CMS Rep. 6, A-04)

D-165.964 Comparing Health Insurance Premium Subsidies and Tax Credits

The AMA's Communications Department will develop a simple, understandable, glossary of terms in Council on Medical Service Report 2-A-04, including, but not limited to refundable and advanceable tax credits. (CMS Rep. 2, A-04)

D-165.965 Federal Health Insurance Reserve System

Our AMA will continue to make the expansion of individual health insurance coverage and choice, using a system of tax credits and improved market regulation, a priority throughout the 2004 political campaigns and beyond. (CMS Rep. 3, A-04)

D-165.966 Giving States New Options to Improve Coverage for the Poor

Our AMA will (1) advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons; and (4) direct the Council of Medical Service to conduct a study of various alternatives and demonstration projects for expanding health insurance coverage for low-income persons and on progress concerning development of new state options for improving the effectiveness of public health safety net programs and report back at the 2005 Annual Meeting. (Res. 118, A-04; Reaffirmed: CMS Rep. 1, A-05; Modified: CMS Rep. 8, A-08)

D-165.967 Health Reimbursement Arrangements

Our AMA will: strongly encourage employers to consider offering Health Reimbursement Arrangements to their employees; and report to the House on the implementation of Health Savings Accounts. (CMS Rep. 3, I-03)

D-165.968 State-Based Demonstration Projects of Our AMA Plan for Reform to Expand Health Care Coverage to the Uninsured

Our AMA will: (1) support federal legislation and/or regulation that would authorize the establishment of state-based demonstration projects to implement refundable, advanceable tax credits inversely related to income as a means of expanding health insurance coverage to the uninsured; and (2) report back to the House of Delegates at the 2004 Interim Meeting on the status of federal legislative and/or regulatory efforts to authorize the establishment of state-based tax credit demonstration projects. (Sub. Res. 704, I-03; Modified:CMS Rep. 8, A-08)

D-165.969 Restructuring Medicare for the Long-Term

Our AMA will: (1) foster a dialogue among potentially interested groups, including but not limited to the Federation, hospital organizations, health policy think tanks, and investment firms, regarding the impending Medicare financial crisis, and promote the AMA proposal for restructuring the program in the short- and long-term;

(2) advocate its proposal for restructuring Medicare in the short- and long-term to 2004 presidential and congressional candidates; and

(3) support the enactment of federal legislation consistent with its proposal for restructuring Medicare in the short- and long-term. (CMS Rep. 5, I-03)

D-165.970 Medical Care for Patients with Low Incomes

Our AMA will continue to work with interested national medical specialty societies, state medical associations, and other relevant organizations as it develops policy recommendations to the House of Delegates for improving the medical care provided to patients with low incomes. Issues to be addressed should include the overall costs of caring for this patient population, options for combining tax credits with other financing mechanisms and insurance market reform, and the provision of a safety net for the most vulnerable segments of the current Medicaid population. All financing mechanisms should be sufficient to adequately fund the overall costs of caring for this patient population and to provide adequate reimbursement to physicians caring for such persons. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06)

D-165.971 Association Health Plans

Our AMA will work with federal legislators to ensure that any Association Health Plan program safeguard state and federal patient protection laws, including but not limited to those state regulations regarding fiscal soundness and prompt payment. (Sub. Res. 125, A-03)

D-165.972 The Federal Employees Health Benefits Program as a Model for Medicare Reform

Our AMA will study the potential advantages that the Federal Employees Health Benefit Program may have to offer as a model for Medicare reform and report its findings back at the 2003 Interim Meeting. (Res. 124, A-03; Reaffirmation I-03)

D-165.973 Health Coverage Tax Credit Program Under the Trade Act of 2002

Our AMA will (1) urge state medical associations to encourage their respective state governments to actively participate in facilitating the implementation of the Health Coverage Tax Credit program under the Trade Act of 2002, and to seek to expand state coverage options available under the program; and (2) inform physicians of the Health Coverage Tax Credit program under the Trade Act of 2002, and encourage them to help make eligible patients aware of the program. (CMS Rep. 11, A-03)

D-165.974 Achieving Health Care Coverage for All

Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States on or before January 1, 2009 that is consistent with relevant AMA policy. (Res. 733, I-02)

D-165.975 Health Care for the Economically Disadvantaged

Our AMA shall continue in its efforts to highlight the need for improved access to quality health care for the disadvantaged, working with the private sector and government at all levels to improve access for this population. (BOT Rep. 18, I-02)

D-165.976 Medical Savings Accounts and Health Care Coverage of Dependents and Children

The AMA encourage the General Accounting Office (GAO) to continue its efforts to conduct a comprehensive survey of medical savings account (MSA) enrollees, including the effect of MSAs on utilization of preventive services. (CMS Rep. 3, I-02)

D-165.977 The Impact of Patient Rights Legislation on Federal Regulations

Our AMA shall continue to keep the House of Delegates informed about the impact of any federal regulations which may be promulgated as a result of passage of federal Patient Bill of Rights legislation. (Res. 219, A-02)

D-165.978 Advocating Health Insurance Tax Credits

(1) Our AMA shall make expanding coverage through the use of refundable and advanceable tax credits a top strategic, communications, and legislative priority for 2003 and the remainder of 2002.

(2) Our AMA shall communicate and advocate its proposal for expanding health insurance coverage through the use of refundable and advanceable tax credits to 2002 Congressional candidates.

(3) Our AMA shall increase its outreach efforts to the employer and business community regarding the benefits of defined contribution systems for employer cost control and employee choice.

(4) The Board of Trustees report back to the House of Delegates regarding AMA Congressional advocacy on the AMA proposal for expanding coverage through the use of refundable and advanceable tax credits and individually owned health insurance. (CMS Rep. 10, A-02)

D-165.980 Tort Reform

(1) Our AMA will convene, as soon as possible, a new coalition comprised of our AMA, state and national medical specialty associations to develop and implement a comprehensive strategic plan that will address all aspects of the growing professional liability crisis, including but not limited to: (a) seeking Federal and state professional liability reform legislation, including a cap on non-economic damages; (b) evaluating and developing methods for improving the adequacy of reimbursement for professional liability expenses under Federal, state and private health insurance programs; and (c) developing mechanisms aimed at reducing the incidence of professional liability lawsuits and their associated costs.

(2) As a complement to new coalition activities on tort reform, our AMA convene an initial planning/strategy meeting on state tort reform, through our AMA Advocacy Resource Center at the January 2002 AMA State Health Legislation meeting.

(3) In advancing any Federal legislative solution to the professional liability crisis, that our AMA closely follow existing policy H-435.964, relating to Federal non-preemption of state constitutional, statutory, regulatory and common laws on professional liability.

(4) Our Board of Trustees report back to the House of Delegates at the Annual 2002. (Sub. Res. 212, I-01)

D-165.981 Transitional Issues in Moving Toward a System of Individually Selected and Owned Health Insurance

(1) Our AMA will inform individual physicians and group practice administrators why self-paying patients (e.g., those who have MSA-type coverage or are uninsured) may be at a significant price disadvantage in purchasing health care services. (CMS Rep. 2, I-01; Reaffirmation A-04)

D-165.982 Medical Savings Accounts and Health Care Coverage of Dependents and Children

Our AMA will study the issue of: (1) medical savings accounts and appropriate health care access and coverage for dependents and/or children; and (2) incentives within MSAs to encourage parents to obtain appropriate preventive medical care for their children or dependents, including how this is accomplished in other countries. (Res. 109, I-01)

D-165.984 Status Report On Expanding Coverage For The Uninsured

Our AMA will continue to vigorously pursue its polices that support a system of refundable, advanceable tax credits inversely related to income for the purpose of expanding coverage and patient choice (Policies H-165.920, H-165.851, and H-165.865). (CMS Rep. 6, A-01; Modified: CMS Rep. 8, A-08)

D-165.985 Evolving Internet-Based Health Insurance Marts

Our AMA will continue to monitor the evolution of the Internet-based health benefits industry and report to the House of Delegates on important developments. (CMS Rep. 5, A-01)

D-165.986 Out of Pocket Expenses in an Individually Selected and Owned Health Insurance System

Our AMA will: (1) encourage physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance; and (2) study the potential problems in transitioning to a system of individually selected and owned health insurance, including but not limited to the price disadvantage of the individual with a Health Savings Account or other high deductible insurance policy. (Sub. Res. 116, I-00)

D-165.987 Modifications to our AMA Standards Benefits Package

Our AMA will undertake no modifications to either our AMA Minimum Benefits Package (Policy H-165.975) or our AMA Standard Benefits Package (Policy H-165.925) at this time. (CMS Rep. 8, I-00)

D-165.989 Managed Care Organization Reimbursement Formulas

Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions. (CMS Rep. 6, A-00)

D-165.991 Medicare Prepaid Competitive Pricing Demonstration Project

Our AMA will oppose the Medicare Prepaid Competitive Pricing Demonstration Project as currently designed. (Sub. Res. 102, I-99)

D-165.992 Antitrust Treatment of Physician Joint Ventures

Our AMA will study opportunities for antitrust relief by utilization and expansion of the National Cooperative Research and Production Act of 1993 to include physician joint ventures, with a report back at I-2000. (Sub. Res. 213, I-99)

D-165.993 Federal Tax Legislation

Our AMA will actively advocate AMA policy H-165.920, which supports the development of Federal Tax legislation which would encourage the independent purchase of health insurance by individuals and families. (Res. 215, A-99)

D-165.994 Status Report on the Uninsured

Our AMA will encourage state medical associations, state specialty societies, and other physician organizations to work with appropriate state agencies to develop innovative programs to expand coverage for the uninsured (CMS Rep. 2, A-99)

D-165.995 Employer Purchasing Alliances: An Evolutionary Step Toward Voluntary Choice Cooperatives" Under Individually Selected and Owned Health Insurance

Our AMA will continue to study existing employer health insurance purchasing alliances that resemble individual "voluntary choice cooperatives" envisioned in the AMA's proposal for individually selected and owned health insurance. (CMS Rep. 5, A-99; Reaffirmation I-03)

D-165.996 Expanding Patient Choice in the Private Sector

Our AMA will continue to place a high priority on the development and implementation of advocacy communications, coalition-building initiatives, and targeted outreach activities as a means of expanding patient choice in the private sector. (BOT Rep. 10, A-99)

D-165.997 Physician Education of Their Patients About Prescription Medicines

Our AMA will support and widely disseminate the Guidelines for Physicians for Counseling Patients About Prescription Medications in the Ambulatory Setting. (CSA Rep. 2, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

D-165.998 Health Plan Coverage for Over-the-Counter Drugs

Our AMA, consistent with Policy H-185.956, will continue to advocate for a wider choice of health plans that would provide greater variation in benefits (CMS Rep. 1, I-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

D-165.999 The Impact of Rapidly Developing Biotechnology on the Delivery of Medical Care

(1) Our AMA Council on Medical Service will continue to study and report on the impact of technological developments on the practice of medicine, the patient-physician relationship, and the physician workforce. (2) Our AMA will accelerate efforts to implement its policy on individually owned and selected health expense coverage (Policy H-165.920), and other policies that promote individual fiscal responsibility for consumption of medical care. (CMS Rep. 14, I-98; Reaffirmed: CMS Rep. 4, A-08)

D-170.000 Health Education

D-170.994 School Health Mentoring Program

Our AMA (1) encourages the Centers for Disease Control and Prevention (CDC) and other appropriate federal agencies to support the development of school health mentoring programs for allopathic and osteopathic volunteer physicians to work with teachers to educate children in grades K through 4 on the importance of good health habits; and (2) will work in collaboration with the Federation to lobby the US Congress for funds to teach early childhood health education in schools. (Res. 410, A-07)

D-170.995 Human Papillomavirus (HPV) Inclusion in High School Education Curricula

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in both males and females, the causal relationship of HPV to genital lesions and cervical cancer, and the importance of routine pap smears in the early detection of cervical cancer; and (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine. (Res. 418, A-06)

D-170.996 Teaching Sexual Education to Disabled Youth in School

Our AMA will encourage the Department of Education to: (1) ensure that mentally and/or physically disabled youth receive effective and comprehensive sexual health education; and (2) offer sexual health education counseling targeted to mentally and/or physically disabled youth. (Res. 406, A-05)

D-170.997 Sun Protection Programs in Elementary Schools

Our AMA will work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (Res. 403, A-05)

D-170.998 Alcohol and Youth

Our AMA will work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. (Res. 415, I-01; Reaffirmation A-08)

D-170.999 Barriers to Appropriate Pain Management

Our AMA, in cooperation with relevant medical societies and organizations, will serve as an educational resource to the media by providing objective information regarding the management of pain disorders so that information presented to the public will be factually accurate reflecting appropriate medical perspectives. (Res. 506, A-01)

D-175.000 Health Fraud

D-175.986 Physician Persecution

Our American Medical Association will consider and take action at the national level on Medicaid fraud prosecutions and related issues. (Res. 212, A-03)

D-175.987 Coding and Valuation of Medicare Emergency Medical Services and Inpatient Hospital Service

The CPT Editorial Panel E&M Workgroup consider new E&M coding guidelines that permit disaggregated claims for E&M services to allow the individual reporting of distinct services provided to patients in single or multiple locations by single physicians or multiple physicians with the same billing number. (BOT Rep. 6, I-01)

D-175.988 Clinical Examples for E&M Documentation Guidelines

(1) The CPT Editorial Panel, in cooperation with medical specialty societies, will work with the Centers for Medicare and Medicaid Services to make E&M coding more straightforward to meet the needs of physicians and to minimize the need for administrative documentation, in a way that is consistent with present AMA policy. (2) The E&M Workgroup and the Editorial Panel consider specialty specific clinical examples as a possible tool to assist physicians in their understanding of the E&M codes. (BOT Rep. 31, I-01)

D-175.989 Business Practices of Aestheticians

Our AMA should: (1) through its Advocacy Resource Center, compile and disseminate to all state medical societies existing state laws defining and limiting the practice of aestheticians; and (2) urge the Federal Trade Commission to consider the issue of advertising by aestheticians, spas, and salons as it relates to treatment of diseases and conditions of the skin. (BOT Rep. 13, I-01)

D-175.990 Stark II Regulations

(1) 0ur AMA will assist its members and constituent state and local medical associations in understanding and complying with the Stark II regulations. (2) State medical societies be urged to generate lists of attorneys claiming expertise in Stark II regulations. (3) Our AMA will work to develop an easily understandable summary of the Stark II regulations for dissemination to practicing physicians. (Res. 204, A-01)

D-175.991 Action to Oppose The Office of Inspector General (OIG) "Draft Compliance Proposed Guidelines for Individual

and Small Group Physician Practices"

Our AMA will: (1) condemn the OIG for its unwarranted punitive attitude and reject the final version of the "Office of the Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" and discourage its members from voluntarily participating the program the until such time that a program is developed which is not burdensome to medical practices and focuses on education rather than criminal punishment; (2) aggressively utilize all available means to have CMS and the OIG appropriately define true fraud and true abuse in fair legal terms and desist in the criminalization of the practice of medicine and focus on education rather than criminal punishment; and (3) pursue such relief through legislative and regulatory advocacy. (Sub. Res. 204, I-00)

D-175.992 Medicare Fraud Analysis

Our AMA: (1) will publicize to physicians, Congress, and the general public the shortcomings and bureaucratic arrogance of the method employed by the Office of the Inspector General Chief Financial Officer Audit;

(2) will strongly urge the U.S. Congress to establish a public technical advisory panel to examine the methodology and results of the Office of the Inspector General Chief Financial Officer Audit;

(3) will strongly urge the U.S. Congress to direct the Department of Health and Human Services to measure the effects on physician practice costs of introducing compliance programs and to adjust all federal payment levels upward to reflect those costs. Such study should also verify or refute the alleged deterrent effects of compliance programs as proposed by the Office of the Inspector General;

(4) will continue to work with federal agencies to improve both their efforts to identify and deter health care fraud and abuse and their estimating and reporting techniques with respect to the extent of health care fraud in federal programs; and

(6) staff will review all possible legal actions that may be taken to challenge the continued release of inaccurate statistics in the OIG CFO Audit. Subsequent to such review our AMA shall undertake the most expedient and effective, if any, legal means to challenge release of the OIG CFO Audit statistics and report its efforts to A-2001. (CMS Rep. 4, I-00)

D-175.993 Health Plan Improper Techniques to Force Physicians to Inappropriately Down Code E and M Services

Our AMA will: (1) immediately review health plans demands to physicians for return of claim payments based solely on the use of statistical analysis of a physician's billing practices;

(2) determine whether health plans demands to physicians for return of claim payments is a violation of the RICO statutes;

(3) seek immediate legislative action and draft model state and federal legislation that would prevent third party payers from demanding a refund of payments based on the use of statistical analysis of a physician's billing practices as the sole criterion for requesting refunds and to provide contractual due process which should include chart review when physician practice patterns are used as the criteria for refund demands; and

(4) draft model state and federal legislation to establish a time limit for refund requests from third party payers and Medicare. (Res. 829, A-00)

D-175.994 Misapplication of Fraud and Abuse Laws

Our AMA: (1) will collaborate with state and component medical societies to develop an educational program for physicians on how to be in compliance with current fraud and abuse laws; and (2) continues implementation of our new web-based fraud and abuse tutorial system, and after careful review upon release of final Physician Office Compliance Guidelines issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services, provide member physicians with information and advice consistent with those guidelines, and to advocate for physicians with the OIG regarding these guidelines, and to advocate for physicians with the OIG regarding these guidelines. (Sub. Res. 244, A-00)

D-175.995 Clarification and Consolidation of Fraud Investigation Units

Our AMA will work with other members of the Federation to educate physicians about their rights and what actions should be taken when confronted with fraud investigations. (Res. 206, I-99)

D-175.996 Persecution by the Department of Justice

Our AMA will: (1) consider joining with other health care professional organizations in legal or legislative actions to cause the government to cease and desist from the use of inflated accusations of fraud and abuse by physicians and health care providers;

(2) study and report, with a detailed settlement analysis, the extent of Medicare fraud and abuse: (a) in total, (b) by physicians (differentiating inadvertent coding errors from inadequate documentation and true fraud), and (c) all other health care providers;

(3) study and report on what elements comprise the government's statistical estimate of Medicare fraud or abuse involving 10% of "all expenditures," and provide us with assurances that the government is not including in that "estimate" the government's other findings of wrongdoing, which does not include physicians and providers; and

(4) study and report on what elements comprise the government's actual settlement of Medicare fraud or abuse, and discourage the government's policy of reporting "estimates" of Medicare fraud or abuse. (Res. 214 & 222, I-99)

D-175.997 Medicare E&M Documentation Guidelines

Our AMA: (1) BOT assume responsibility for implementing the E&M documentation system changes that were mandated by our AMA Policy H-175.978; (2) will work with CMS to fully implement, test and appropriately evaluate E&M pilot projects prior to adopting a new E&M documentation system; and (3) BOTwill appoint an Ad Hoc Task Force composed exclusively of full-time, actively practicing, physicians charged with identifying problems in and proposing solutions for the E&M documentation system. (Res. 836, A-99)

D-175.998 Bounty on Fraud and Abuse

Our AMA will: (1) express the anger and outrage of physicians towards CMS and the AARP for their demonstrated disregard for the doctor-patient relationship, and for CMS's continued mistreatment, disrespect, and public defamation of physicians by repeated unwarranted implications of widespread fraudulent behavior by physicians;
(2) use all available means to have CMS immediately rescind the policy of paying a "bounty" to patients for reporting their physicians;
(3) insist on a public apology from CMS to the AMA and to all physicians who are innocent of fraudulent billing, and that CMS immediately cease and desist from an ongoing pattern of behavior that demeans, defames, and discredits the public's perception of all decent physicians; and
(4) seek an independent audit of all expenses under Medicare Part B to determine the extent of the problem CMS defines as "fraud." (Res. 202, A-99)

D-180.000 Health Insurance

D-180.983 Components of Health Insurance

Our AMA will study and clearly spell out to what extent a prepaid health service component and a risk-based component contribute to the costs of health insurance, and report back to the House of Delegates. (Res. 111, A-08)

D-180.984 Payer Measures for Private and Public Health Insurance

Our AMA will work with state medical associations, employer coalitions, physician billing services, and other appropriate groups to evaluate on an annual basis and recommend standards for "payer measures" for the insurance industry and government payers to be publicly reported for consumers that may include information such as:

1. Number of patients enrolled
2. Total company and individual plan revenue/expense and profit
3. Procedures covered and not covered by policy
4. Number of primary and specialist physicians
5. Number of denied claims (and %)
a. Number denied based on "pre-existing condition"
b. Number denied and later allowed
c. Number denied for no reason
6. Waiting time for authorization of common procedures
7. Waiting time for authorization of advanced procedures
8.Waiting time for payment
9. Morbidity and mortality due to denied or delayed care
10. Number of appeals by customers or physicians
11. Number of successful appeals by customers or physicians
12. Number of consumer complaints
13. Number of government fines/sanctions
14. Use of economic profiling of physicians to limit physicians on panel
15. Use of quality measures approved by qualified specialty societies (Res. 703, I-06; Reaffirmation A-07; Reaffirmed in lieu of Res.

828, I-08)

D-180.985 Health Plan and Insurer Transparency

Our AMA will:
(1) continue to closely monitor any new "transparency" programs unveiled by health plans to determine the impact on physicians;
(2) communicate to health plans, employers and patients our concerns about current "transparency" programs, and educate them about "true transparency"; and
(3) continue to educate physicians about the complexities of claims adjudication and payment processes to enable them to more efficiently manage their practices. (BOT Rep. 19, A-06; Reaffirmation A-07)

D-180.986 Update on the Individual Health Insurance Market

Our AMA will: (1) provide information to the public about the availability of health insurance on the individual market; and (2) encourage local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers. (CMS Rep. 6, A-05)

D-180.987 Elimination of Federal Government Discrimination Against Individuals Who Purchase Health Insurance

Our American Medical Association seek to eliminate federal government discrimination against individuals who purchase health insurance on their own rather than through an employer, by pursuing equitable tax treatment for health insurance premiums. (Res. 726, I-02; Modified: CMS Rep. 8, A-08)

D-180.988 National Regulation of Health Insurance Markets

Our American Medical Association: (1) study the benefits and risks of national health insurance regulation, and report back to the House of Delegates by the 2003 Interim Meeting; and (2) thoroughly review the McCarran-Ferguson Act and seek a legal opinion whether the scope of the McCarran-Ferguson Act is limited to "risk rating and risk spreading" involving insurance companies and does not protect anti-competitive market dominant behavior by insurance companies and, based on such opinion, consider asking Congress to clarify the limited scope of the McCarran-Ferguson Act. (Res. 725, I-02)

D-180.989 Study of Administrative Costs of Government and Private Health Insurance Programs

Our AMA shall cause that a follow-up study to the 1994 Council on Affordable Health Insurance study covering Medicare and Medicaid be completed expeditiously, and that the completed study be disseminated to state and specialty medical societies and other interested parties. (Res.715, I-02)

D-180.990 Health Reimbursement Arrangements

Our AMA study the possibilities afforded by Health Reimbursement Arrangements to accomplish the objectives of Medical Savings Accounts and report its findings to the House of Delegates at the 2003 Annual Meeting. If our AMA finds that Health Reimbursement Arrangements are a desirable way to promote more individual patient choice and control, it will recommend a strategy to promote the concept among employers. (Res. 807, I-02)

D-180.991 Work Plan for Maintaining Privacy of Physician Medical Information

The AMA shall recommend that medical staffs, managed care organizations and other credentialing and licensing bodies adopt credentialing processes that are compliant with the Americans with Disabilities Act and communicate this recommendation to all appropriate entities. (BOT Rep. 7, I-02)

D-180.992 Most Favored Nation Clauses

Our AMA shall prepare model legislation to eliminate the use of "Most Favored Nation" clauses in insurance contracts as barriers to offering affordable medical care. (Res. 701, A-02)

D-180.993 Prompt Initial Credentialing of Physicians by Managed Care Plans

Our AMA will: (1) continue to work with relevant entities, such as the National Committee for Quality Assurance (NCQA), the American Accreditation HealthCare Commission/URAC, and the Centers for Medicare and Medicaid Services (CMS), to adopt AMA policies related to the timely credentialing of physicians; (2) develop model state legislation to effect AMA policy on the timely credentialing of physicians; and (3) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on timely credentialing by their state legislatures. (Sub. Res. 701, I-01)

D-180.994 Rescinding Provisions Requiring Physicians to Have Hospital Admitting Privileges

Our AMA will work with the American Association of Health Plans, Health Insurance Association of America, and other appropriate organizations to rescind provisions requiring physicians to have hospital medical staff privileges in order to participate in health plans, and report to the House at A-02. (Res. 716, A-01; Reaffirmation A-04)

D-180.995 Physician Privileges Application -Timely Review by Managed Care

Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans. (Res. 708, A-01)

D-180.996 Clearinghouse on Disputes with Third Party Payers

Our AMA: (1) will establish an information clearinghouse whereby physicians could report information about administrative disputes that they encounter with third party payers; (2) information clearinghouse on physicians' administrative disputes with third party payers will be administered and coordinated by the AMA Division of Private Sector Advocacy so that information is gathered and shared on a regular basis to identify trends and to facilitate effective, legally appropriate action by physicians and their representative organizations to solve administrative and payment problems with third party payers; and (3) Division of Private Sector Advocacy continue to assist the Federation in collecting data on physicians' administrative and payment problems with health plans and make relevant information from these data collection efforts available on its Web site. (Res. 701, A-01)

D-180.997 Informed Medical Decision - Making by Prospective and Current Health Organization Enrollees

Our AMA will report to the House of Delegates at the 2001 Annual Meeting on the status of the implementation of Board of Trustees Report 3 (I-97). (Sub. Res. 708, I-00)

D-180.998 Insurance Parity for Mental Health and Psychiatry

Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. (Res. 215, I-98; Reaffirmation I-03; Reaffirmed in lieu of Res. 910, I-06)

D-185.000 Health Insurance: Benefits and Coverage

D-185.989 Expanding Health Insurance Coverage to the Uninsured: 2007 and Beyond

Our AMA will:
(1) review the appropriate scope of required health insurance benefits for such benefits to qualify for purposes of tax credit or other federal subsidy;
(2) review the financing of health care for and/or insurance coverage for those with chronic illness or who are experiencing catastrophic health expenses; and
(3) conduct new tax credit simulations on varying components of its proposal to expand health insurance coverage and choice. (CMS Rep. 5, I-06)

D-185.990 Health Insurance Coverage of Specialty Pharmaceuticals

Our AMA will continue to monitor health plan treatment of specialty pharmaceuticals to ensure patient access to needed pharmaceuticals, and report back to the House of Delegates at the 2006 Interim Meeting. (CMS Rep. 2, I-05)

D-185.991 Health Care for the Victims of the Postal Anthrax Attacks of 2001

Our AMA will (1) advocate the issue of health plans' responsibility to pay for health services provided to victims for anthrax-related medical care as a result of the 2001 postal anthrax attacks with the appropriate federal agencies, such as the Office of Personnel Management, and with the trade association representing the health insurance industry, e.g., America's Health Insurance Plans; and (2) study how the "act of war" exclusion in health insurance contracts should be defined and examine ways that the AMA might work with health insurance companies to ensure that individuals injured as a result of future bioterrorism events receive appropriate health care that is covered by their insurance policies. (BOT Rep. 9, A-05)

D-185.992 CMS Rule Regarding Route of Administration of Drugs

Our AMA will (1) request the Centers for Medicare and Medicaid Services (CMS) to change the current rule regarding the determination of self-administered drugs so that each route of administration is independently calculated to determine the 50% rule in considering whether the drug is covered; and (2) encourage Congress to amend this portion of Section 112 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Benefits Improvement Act of 2000 (BIPA 2000) to allow for such a change if CMS cannot change the rule. (Res. 127, A-04)

D-185.993 Advocacy for Repeal of the Uniform Individual Accident and Sickness Policy Provision Law (UPPL)

Our AMA will support state and specialty medical societies and the public health associations in their efforts to secure repeal of laws and state insurance codes which allow for the denial of insurance payments for the treatment of injuries sustained as a consequence of the insured person being intoxicated due to alcohol or under the influence of narcotics. (Res. 912, I-03; Reaffirmed: CSAPH Rep. 8, A-06)

D-185.994 Mental Health Parity

Our AMA, along with the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, will circulate a letter for state medical societies and specialty societies to sign urging the United States Senate and House of Representatives to bring federal mental health insurance coverage parity legislation to a vote during the 108th Congress. (Res. 706, A-03; Reaffirmation I-03; Reaffirmed in lieu of Res. 910, I-06)

D-185.995 Health Plan Coverage of Prescription Drugs

Our AMA will: (1) advocate AMA policies related to health plan coverage of prescription drugs to pharmacy benefit managers, as well at to public and private sector payers; and (2) advocate for the enactment of legislation consistent with AMA policies related to health plan coverage of prescription drugs. (CMS Rep. 6, A-03; Reaffirmation I-04)

D-185.996 Disclosure of Fee Schedules

Our AMA will sponsor legislation to require all health plans in the United States to disclose their payment fee schedules in US dollars to affected physicians with promptness and in adequate detail. (Res. 217, I-01)

D-185.997 Coverage for Periodic Preventive Medical Evaluations and Services

Our AMA will study the impact of insurance coverage for evidence-based preventive services and prospective medical evaluations on the health of our patients, and the financial impact on the health care system, including options for payment. (Res. 133, A-01)

D-185.998 Litigation Regarding Patient Care Guidelines

Our AMA will: (1) continue to monitor Batas v. Prudential and provide such support as may be appropriate; and (2) aggressively seek other opportunities to challenge the misuse of M & R and similar patient care guidelines. (BOT Rep. 4, I-00)

D-185.999 Information Included On Health Insurance Identification Cards

Our AMA will continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing. (Sub. Res. 828, A-99; Modified: Sub. Res. 713, A-08)

D-190.000 Health Insurance: Claim Forms and Claims Processing

D-190.976 Internet Submissions of Medicare Claims

Our AMA: (1) will develop principles describing appropriate use of the Internet in submitting Medicare claims; and (2) supports the use of high speed Internet as a mechanism to file Medicare claims with appropriate safeguards that adhere to federal law and HIPAA standards to ensure the protection of patient health information. (Res. 836, I-08)

D-190.977 Insurance Reimbursements

Our AMA will: (1) seek legislation requiring managed care companies and any third party carrier including Medicare to request a refund from physicians in the same time period they give physicians to file a claim in the contract; and (2) seek legislation that managed care companies and any third party carrier including Medicare in no case be allowed more than 180 days to request a refund from a physician. (Res. 908, I-06)

D-190.978 HIPAA Privacy Regulations

The AMA will:

1. Not support repeal of the final privacy rule under the Congressional Review Act because the time for Congress to act under that Act has passed.

2. Continue its current strong advocacy efforts to improve and strengthen the final privacy rule while decreasing the administrative burdens it places upon physicians and other health care providers.

3. Partner actively with other relevant groups, such as state and national specialty medical societies, to look for other options for improvement and change and forward these to Department of Health and Human Services Secretary Thompson.

4. Communicate frequently with all interested parties about the progress of this process. (BOT Action in response to referred for decision Res. 240, A-01)

D-190.979 HIPAA and Foreign Outsourcing

Our AMA will: (1) encourage physicians to be careful that business associate agreements with overseas business associates adequately safeguard the privacy and security protections for patients set forth in the Health Insurance Portability and Accountability Act and encourages physicians to perform adequate and appropriate due diligence prior to entering into relationships with overseas business associates and (2) investigate ways to protect physicians from HIPAA violations when they have contracted for services in good faith and report back to the House of Delegates at the 2006 Annual Meeting. (BOT Rep. 8, I-05)

D-190.980 Problems Encountered with WebMD and Other Clearinghouses

Our AMA will: (1) continue its efforts to assist physicians to correct the health insurance claims transaction problems they are experiencing with WebMD and other clearinghouses; and (2) monitor the situation and be available to consult with AMA members and their legal counsel regarding legal action against WebMD or other clearinghouses, including holding them financially liable for any losses to physicians resulting from clearinghouse submission errors. (Res. 710, A-04; Reaffirmed in lieu of Res. 722, A-06)

D-190.981 Provision of Updated Billing Software by CMS

Our AMA will continue to work with Centers for Medicare and Medicaid Services to identify ways to make the submission of claims to Medicare more efficient and less costly. (BOT Rep. 9, A-04)

D-190.982 HIPAA Extension

Our AMA will: (1) support necessary legislative and/or regulatory changes to mandate that health plans continue to accept non-standard electronic claims from physicians during a reasonable transition period following October 16, 2003, when the HIPAA transaction rule takes effect, and (2) take steps to assure that Medicare continues to support free software for filing claims to Medicare and that payers continue to accept paper claims from physicians who choose to submit claims on paper. (Res. 224, A-03)

D-190.983 Protection of Health Care Providers from Unintended Legal Consequences of HIPAA

Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation. (Res. 204, A-03)

D-190.984 HIPAA

Our AMA continue to identify and work toward the repeal of the onerous provisions in the Health Insurance Portability and Accountability Act legislation and regulations, including its criminal liability provisions, and that our AMA work to redress the breaches of patient confidentiality that the HIPAA regulations have allowed. (Res. 901, I-02)

D-190.985 Standardization of Disability Forms

The AMA approach the Health Insurance Association of America to determine if there is industry interest in the development of a standardized disability claim form and, if a positive response is received, that a detailed proposal for completing such a project -

including potential costs - be developed for consideration by the Board of Trustees. (BOT Rep. 5, I-02)

D-190.986 Provision of Payment Schedules and Methodology of Payment as Part of the Contracting Process

Our AMA shall provide the AMA membership with a legal "blueprint" that can be used by other state medical associations/societies in pursuing a ruling for their individual members that is similar to that used by the Medical Association of Georgia in obtaining relief from payment contract practices which do not disclose the full term of reimbursement. (Res. 719, A-02; Reaffirmation A-08)

D-190.987 AMA Advocacy of Prompt Pay Initiatives

Our AMA shall: (1) continue to advocate Policy H-190.981, and monitor and report to the House of Delegates on delayed payment to physicians by health plans, as appropriate; and (2) study the issue of how ERISA impedes the application of state prompt pay laws and report back at the 2002 Interim Meeting with recommendations on eliminating ERISA impediments to application and enforcement of state prompt pay statutes. (Sub. Res. 715, A-02; Reaffirmation I-04)

D-190.988 HIPAA interference with Peer Review Activities

Our AMA shall seek immediate clarification from the Department of Health and Human Services of the impact of the Health Insurance Portability and Accountability Act Privacy Rule on the peer review process. (Res. 721, A-02)

D-190.989 HIPAA Law And Regulations

(!) Our AMA shall continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care.

(2) If satisfactory modification to the HIPAA Privacy Rule is not obtained, our AMA shall aggressively pursue appropriate legislative and/or legal relief to prevent implementation of the HIPAA Privacy Rule.

(3) Our AMA shall continue to oppose the creation or use of any unique patient identification number, including the Social Security number, as it might permit unfettered access by governmental agencies or other entities to confidential patient information.

(4) Our AMA shall immediately begin working with the appropriate parties and trade groups to explore ways to help offset the costs of implementing the changes required by the Health Insurance Portability and Accountability Act so as to reduce the fiscal burden on physicians. (Sub. Res. 207, A-02)

D-190.990 Federal Funding for Liability for Physicians Working in Free Clinics

Our AMA shall implement a plan to have regulations and funding for Section 194 of the HIPAA bill approved, which states that liability coverage for physicians volunteering in free clinics will be provided through the US Public Health Service, and will continue to monitor the implementation of Section 194 of HIPAA. (Res. 226, A-02; Appended: BOT Rep. 17, A-04)

D-190.991 Automatic Crossover of Payment Between Medicare and Medicaid

Our AMA shall seek changes in federal legislation, to mandate that patients with both Medicare and Medicaid have their claims electronically forwarded from Medicare to Medicaid so that the claims are processed in a prompt and reasonable fashion. (Res. 118, A-02)

D-190.992 HIPAA Privacy Regulations Implementation

Our AMA shall continue to make it an urgent priority to undertake a comprehensive review including unfunded physicians costs of implementation of HIPAA transaction, privacy and security rules to identify provisions that should be clarified, improved or repealed and communicate there urgently needed changes to the Department of Health and Human Services and Congress for prompt action, including any necessary delays in implementation, as appropriate. (Sub. Res. 216, I-01)

D-190.993 Electronic Claims

Our AMA will use all appropriate means to advocate AMA policy regarding the timely notification of receipt and acceptance or rejection for processing of electronic claims. (Res. 707, A-01)

D-190.994 Claims Denial and Payment Delays

Our AMA will strongly promote AMA policy regarding the filing date of claims and provide a report on the progress at A-02. (Res.

705, A-01)

D-190.995 Uniform Clinical Criteria for Level of Care Status

Our AMA will study: (1) the problem of variation in designation of level of care status (ambulatory, observation versus inpatient), by insurance companies, managed care companies and the Centers for Medicare & Medicaid Services; and (2) the feasibility of working with appropriate associations and agencies to develop uniform, evidence-based, clinical criteria for designation of level of care status. (Res. 707, I-00)

D-190.996 ERISA and Health Plan Related Legislation

Our AMA will continue to urge state medical associations to undertake surveys of their members regarding payment delays by health plans so that physicians will be aware of plans that are delaying payment and that may be financially weak. (BOT Rep. 17, I-00)

D-190.997 CMS, Y2K, and the Uncertainty Principle

Our AMA strongly request that CMS stand by its claim that all systems are ready and publicly retract its earlier statement that payments will be delayed until January 17, 2000 and further announce that Medicare claims will be paid on time and according to the updated physician payment schedule. (Res. 129, I-99)

D-190.998 Proposed CMS 1500 Claim Form Changes

Our AMA will: (1) notify the National Uniform Claim Committee (NUCC) and CMS that the proposed claim form is not acceptable and is too expensive to utilize; and (2) work with the NUCC to obtain physician input in the development of future changes to the claim form. (Res. 125, I-99)

D-190.999 Y2K Diagnostic Report Dates

Our AMA will work to facilitate an agreement with CMS so that Medicare will accept a date stamp initialed by technicians on all diagnostic testing reports performed by equipment with Y2K date problems. (Res. 120, A-99)

D-195.000 Health Maintenance Organizations

D-195.997 Time to Revisit Health Maintenance Organization Act

Our AMA will provide an update on the impact of the Health Maintenance Organization Act of 1973. (Res. 214, A-03)

D-195.998 HMO Excesses

Our AMA will update, reorganize and consolidate information on the current status of litigation, regulations and laws controlling HMO practices, which exists currently on public portions of our AMA Internet site, into a new user-friendly site for AMA members only. (Res. 719, A-03)

D-195.999 Patient Reporting of Insurance Company Fraud and Abuse

Our AMA will encourage state medical associations to use language similar to that developed by the Florida Medical Association, entitled "How’s Your HMO/Insurance Company Treating You?," in order to provide information that will be helpful to patients if they have complaints about their HMOs and insurance companies. (Res. 704, I-00)

D-200.000 Health Workforce

D-200.979 Barriers to Primary Care as a Medical School Choice

1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services:

a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions.
b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS.

2. In collaboration with relevant specialty societies, our AMA will study the following related to new models of provision of primary care services (such as the medical home concept):

a. the impact on primary care physician work-life balance and satisfaction,
b. the growth/expansion of such models in the public and private sectors,
c. the availability of expanded public- and private-sector funding at the national and local levels to support implementation of such models.
d. the impact on primary care physician compensation.
e. options that explore additional funding.

The results of the study shall be reported no later than the 2010 Annual Meeting of the AMA House of Delegates.

3. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty.

4. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions.

5. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice.

6. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including:

a. admissions policies
b. utilization of primary care physicians in the roles of teachers, mentors, and role models, and
c. educational experiences in community-based primary care settings. (CME Rep. 3, I-08)

D-200.980 Effectiveness of Strategies to Promote Physician Practice in Underserved Areas

1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following:
(a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations.
(b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program.
(c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.

2. Our AMA, through its Initiative to Transform Medical Education, will study and report back to the House of Delegates at the 2010 Annual Meeting on:
(a) medical school admissions policies designed to attract medical students who will practice in underserved areas or with underserved populations;
(b) the availability of educational opportunities for medical students and residents in rural and urban underserved areas; and
(c) the efficacy of community-based initiatives such as the Area Health Education Center Programs and their impact on supply of physicians to the area.

3. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.

4. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas. (CME Rep. 1, I-08)

D-200.981 Gender Disparities in Physician Income and Advancement

Our AMA:

(1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;

(2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;

(3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;

(4) will collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and

(5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit. (BOT Rep. 19, A-08)

D-200.982 Diversity in the Physician Workforce and Access to Care

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. (CME Rep. 7, A-08)

D-200.983 Barriers to Primary Care as a Medical Career Choice

Our AMA will (1) explore the barriers to primary care medicine as a career choice and the impact of these barriers on the profession of medicine as a whole and on access to health care in the United States; and (2) report back at the 2008 Interim Meeting its findings and plan of action. (Sub. Res. 601, I-07)

D-200.984 Incentive Programs to Improve Access to Care in Underserved Areas

1. Our American Medical Association, in collaboration with state and medical specialty societies, will continue to collect and disseminate information on the efficacy of various types of incentive and other programs designed to promote recruitment and retention of physicians in underserved areas.

2. Based on the analysis of the efficacy of the various types of incentive programs, our AMA will advocate to the federal government, the states, and the private sector for enhanced support for successful models.

3. A report on the outcomes of further study and actions taken related to incentive programs to improve access to care in underserved areas will be prepared for the 2008 Interim Meeting of the House of Delegates. (CME Rep. 4, A-07)

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:
a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school;
b. Diversity or minority affairs offices at medical schools;
c. Financial aid programs for students from groups that are underrepresented in medicine; and
d. Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Through the identification of models and strategies at the national and state/regional levels, our AMA will study and report back at the 2009 Annual Meeting on the following:
a. The status of efforts to assure adequate funding for diversity initiatives;
b. The current status of underservice and access to care in the US (regionally and by population); and
c. The recruitment and retention of physicians to practice in underserved areas and to work with underserved populations.

6. Our AMA will collaborate with the AAMC, the Educational Commission for Foreign Medical Graduates, and the Federation of State Medical Boards to study the contribution of international medical graduates to the overall diversity and distribution of the US medical workforce and report at the 2008 Annual Meeting. (CME Rep. 1, I-06)

D-200.986 Impact of Increasing Specialization and Declining Generalism in the Medical Profession

Our AMA will:

(1) Develop policy regarding the development and maintenance of the appropriate workforce balance between generalists and specialists in its Initiative to Transform Medical Education and in future studies or deliberations related to the medical workforce.

(2) Through its Council on Medical Education, continue its close collaborations with the Association of American Medical Colleges, American Board of Medical Specialties, and Accreditation Council for Graduate Medical Education by actively participating in processes which define the content and scope of education and practice, including participation in defining medical school curriculum through the Liaison Committee on Medical Education and reviewing and commenting on proposed changes in the accreditation requirements of Graduate Medical Education programs by the ACGME.

(3) Continue to seek input from the Federation on the need for physicians by both geographic region and specialty.

(4) Support the concept of partnerships between primary care physicians and patients to coordinate access to all needed medical services and consultations (a “medical home”) for all patients.

(5) Encourage physician reimbursement changes which would make generalist physician practice more attractive.

(6) Work with the Federation to convene and staff a "medical workforce commission" (which would include representatives of the medical education community, major specialty societies and the public) to project the optimal medical workforce for the US and to develop strategies to achieve that. (CME Rep. 12, A-06; Reaffirmation I-06)

D-200.987 Physician Re-Entry

Our AMA, in collaboration with appropriate state and specialty societies, the Accreditation Council on Graduate Medical Education, the American Board of Medical Specialties, and the Federation of State Medical Boards, will study the issue of physician re-entry into practice after a leave of absence from practice or a limitation of certain aspects of practice, including a consideration of issues related to retraining, certification, and credentialing. The study on physician re-entry into practice will also assess the overall impact of re-entry issues on the physician workforce. (Res. 316, A-06)

D-200.988 Strategies for Increasing Diversity in the Health Care Workforce

Our AMA commends the Institute of Medicine on its report, "In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce," and will develop recommendations for specific strategies to increase workforce diversity with a report back to the House of Delegates at the 2007 Annual Meeting. (Res. 304, A-06)

D-200.989 Incentive Programs to Improve Access to Health Care Services in Underserved Areas

Our AMA will (1) conduct an analysis of the creative use of tax credits, student loan deferment and loan forgiveness programs, J-1 visa waivers, and practice subsidies as financial incentives to physicians for providing care in identified underserved areas; and (2) work with state medical societies and other appropriate entities to identify, catalogue, and evaluate the effectiveness of incentive programs, including the J-1 visa waiver program, designed to promote the location and retention of physicians in rural and urban underserved areas and, consequently, improve patient access to health care in these areas. (Res. 810, I-05; Reaffirmation I-06)

D-200.990 Physician Workforce and the Future of Emergency and Trauma Care

Our AMA will (1) convene a work group with the specialties affected by the impending shortage of specialists for emergency and trauma care and those organizations closely involved in physician workforce issues to develop solutions to the problem of the undersupply of specialist physicians and the future of emergency and trauma care; and (2) utilize the recommendations of this working group to develop comprehensive, long-term legislative and regulatory proposals that will address the problem of the undersupply of specialist physicians caring for children and adults and the future of emergency and trauma care for these patients. (Res. 309, A-05; Reaffirmation I-06)

D-200.991 The Physician Workforce: Recommendations for Policy Implementation

To address current and predicted physician shortages, our AMA will work with members of the Federation and national and regional

policymakers to develop mechanisms, including identification of funding sources, to create medical school and residency positions in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 8, A-05; Reaffirmation I-06; Reaffirmation I-07)

D-200.992 US Physician Shortage

Our AMA will draft a report outlining policy options to address the US physician supply. (Res. 807, I-03)

D-200.993 Revisions to AMA Policy on the Physician Workforce

Our AMA will, through its Councils, Sections, Minority Affairs Consortium, and other organizations, develop strategies to implement its workforce policy, through research, advocacy, and other relevant means; and collaborate with state and specialty societies and other interested groups to develop a national consensus on physician workforce policy. (CME Rep. 2, I-03; Reaffirmation I-06)

D-200.994 Appropriations for Increasing Number of Primary Care Physicians

Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747. Res. 814, I-03)

D-200.995 Federal Grants to Serve Medically Underserved Areas

Our AMA will encourage physicians interested in the availability of federal grants available for service in medically underserved areas, to review the information on the US Department of Health and Human Services web site at www.hhs.gov/grantsnet. (CMS Rep. 2, I-03)

D-200.996 Updating Physician Workforce Policies

Our AMA, with direct input from AMA Councils and Sections and Special Groups, shall examine current AMA policy on physician workforce planning, and make new recommendations as necessary. (Res. 306, A-02)

D-200.997 Job Data Bank

The enhanced website described in this report should be available to the members of the AMA at no charge and be available to non-members at a fee. (BOT Rep. 7, A-01)

D-200.998 Physician Workforce Planning and Physician Re-Training

Our AMA will (1) consider physician retraining during all its deliberations on physician workforce planning; and (2) assess the extent of physician retraining needs by appropriately surverying all U.S. residency programs, to identify the number of physicians undergoing specialty retraining, and to report its findings to the House of Delegates at A-2000. (Res. 324, A-99)

D-205.000 Health Planning

D-205.999 Profession of Medicine

Our AMA will initiate efforts to educate the presidential candidates selected by the major political parties about the importance of promoting health care initiatives, consistent with the Association's policies and principles, that enable patients and physicians to direct health care for the future. (Sub. Res. 920, I-07)

D-210.000 Home Health Services
(See also: Medicare)

D-210.997 Home Infusion Therapies

Our AMA will: (1) work with the Centers for Medicare and Medicaid Services to develop a coordinated system among the various Medicare plans to ensure an expedited, seamless process for provision of home infusion therapies to reduce the need of the patient to remain in the hospital unnecessarily; and (2) work with home infusion stakeholders to seek a legislative remedy to Medicare's lack of coverage for the services, supplies and equipment necessary to provide infusions in the home setting. (Res. 718, A-08)

D-210.998 Mandated Medicare Transfer of Title of Home Oxygen Equipment

Our AMA will formally submit comments to Congress and the Centers for Medicare and Medicaid Services expressing opposition to

the home oxygen system title transfer provision of the Deficit Reduction Act. (Res. 913, I-06)

D-210.999 Physician Responsibility for Nursing Agencies

Our AMA will advocate to CMS that, prior to a patient's release from the hospital, post-acute and long-term care (i.e., post-hospital care for sub-acute and chronic illnesses in a variety of health care settings, such as home health agencies and skilled nursing facilities) agencies and facilities be required to include order sheets listing the services that the agencies or facilities would like to render to the patient as part of the certification form. Physicians could then check off those services that they believe their patients should receive. (CMS Rep. 1, A-00)

D-215.000 Hospitals

D-215.992 AMA Advocacy Report on the Advantages and Disadvantages of Certificate of Need Laws

1. Our AMA Board of Trustees will prepare a report addressing the benefits and risks to our members, our patients and to the business and employer communities of elimination of Certificate of Need (CON) laws and regulations that restrict the development of physician-owned ambulatory surgery centers, procedural and imaging centers and laboratories and ancillary services.
2. Our AMA report advancing the practicing physician's perspective on CON elimination will include an analysis of the major components of our adversaries' positions.
3. Our AMA Board will report back at the 2007 Annual Meeting. (Res. 820, I-06)

D-215.993 Corporate Practice of Medicine

Our AMA will:

(1) provide guidance and consultation in drafting state legislation to medical societies which are concerned that physician employment by non-physician organizations may be interfering in professional medical matters, if asked; and that the legislation state that all patient care decisions should be made only by the treating physician for the benefit of the patient;

(2) revise its economic credentialing model legislation to encompass recent economic credentialing strategies, and make this model available to state and national medical societies; and

(3) develop model legislation, based on SB 1325 that was recently enacted in California, which would protect medical staffs from board interference regarding specific medical staff activities (e.g., election of officers and retention of independent legal representation), and make this model legislation available to state and national specialty societies. (BOT Rep. 9, I-05)

D-215.994 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations

Our AMA will study the possible anti-competitive and ethical implications of an expectation that referrals among health care providers remain within an integrated hospital system physician group, regardless of whether such an expectation is directly stated or indirectly implied or rewarded. This study should focus on situations in which there is a choice in referrals among equally competent, competing physicians, and such choice is not precluded by insurance coverage restrictions. Recommendations for new policy, legislation or regulations should be included. (Res. 721, A-05)

D-215.995 Specialty Hospitals and Impact on Health Care

Our AMA will:

(1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest;

(2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care;

(3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients;

(4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital;

(5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities; and

(6) continue to monitor the specialty hospital issue and report back to the House of Delegates at the 2005 Annual Meeting. (BOT Rep. 15, I-04)

D-215.996 Specialty Hospitals and Impact on Health Care

Our AMA will comprehensively study the issue of specialty hospitals to determine: (1) their wide-ranging impact on the provision of health care; (2) competitive pressures and tactics used by hospitals and others to stop the building of specialty hospitals; (3) known and potential benefits associated with specialty hospitals including quality of care improvements; patient satisfaction and cost effectiveness; (4) the financial impact on community hospitals and "safety net" institutions, access to emergency and trauma care services, and the quality of physician training programs; (5) the appropriateness of physician referral patterns; and (6) any other issues relating to specialty hospitals that may impact quality of care. (Res. 707, A-04)

D-215.997 Hospital Merger Study

Our AMA resources regarding hospital mergers, acquisitions, consolidations, affiliations, and break-ups should be made available in one location on the AMA Web site to assist physicians seeking guidance on this issue. (CMS Rep. 4, I-01)

D-215.998 Preservation of the Mission of DC General Hospital and Its Affiliated Community Health Centers

Our AMA: (1) will send a letter calling upon the Mayor of Washington, DC, the City Council, the city's "Control Board" and the city's congressional oversight committees to develop the city, federal and private resources needed to sustain DC General Hospital and its affiliated community health centers until a new facility can be developed for more cost-effective delivery of health care to the underserved of our nation's capital. (2) Board of Trustees will report on the effects of closing safety-net hospitals as well as the fate of DC General Hospital and its affiliated community health centers at 2001 Interim Meetings of the House of Delegates. (Res. 425, I-00)

D-215.999 Medicare Exclusion

Our AMA seeks Congressional direction to the Centers for Medicare & Medicaid Services and the Office of the Inspector General that a hospital will not be excluded from Medicare or any other federally funded program solely because a member of its medical staff has been excluded from Medicare or other federally funded program. (Res. 120, I-99)

D-220.000 Hospitals: Accreditation Standards

D-220.972 Expanding Physician and Medical Staff Participation in Accreditation Surveys

Our AMA will endorse and promote the use of actively practicing physicians as surveyors by The Joint Commission and other organizations with deeming authority in their processes to survey for compliance with medical staff standards and state requirements. (Res. 843, I-08)

D-220.973 Effective AMA Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage

Our AMA:

(1) will work with The Joint Commission to consider nurse staffing as a national patient safety goal and to examine the Hospital Accreditation Standards at NR.3.10 (regarding nursing policies and procedures, nursing standards, and nurse staffing plans), LD.3.15 (regarding management of the flow of patients to mitigate patient crowding and ensure appropriate care of patients in temporary locations), and HR.1.10-1.1.20 (regarding the hospital staffing plan and the qualifications of staff), to ensure that nursing staffs are adequate relative to patient number and acuity, are competent, and are appropriately oriented and trained in specialized departments;

(2) supports professional nursing associations in their efforts to educate the public and advocate for programs aimed at protecting patient safety by ameliorating the RN shortage in hospitals;

(3) encourages hospital organized medical staffs to take steps to improve the working environment and professional standing of nurses in hospitals in order to improve the quality and safety of patient care;

(4) will provide reports to the House of Delegates at the 2008, 2009 and 2010 Annual Meetings detailing progress made in its efforts to address the nursing shortage. (Res. 534, A-07)

D-220.974 The Joint Commission Leadership Standards

Our AMA will encourage the AMA Commissioners to The Joint Commission to: (1) express AMA support for the Leadership Standards, Elements of Performance (EPs) and definitions for hospital accreditation that pertain to the organized medical staff's critical leadership role in hospital operations as well as clinical policies; (2) work to retain those Leadership standards, EPs and definitions; and (3) work on an ongoing basis to refine and strengthen medical staff self-governance in the Leadership Standards, and in all relevant Joint Commission standards. (Res. 533, A-07)

D-220.975 JCAHO Transparency

1. Our AMA Commissioners to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be asked to advocate for a truly open and transparent comment process for all proposed changes to JCAHO standards.

2. It is AMA policy that: (a) all proposed changes to JCAHO standards resulting from field reviews be published along with clearly stated rationale(s) for each proposed change; (b) all proposed changes to JCAHO standards be published along with clearly stated identities of entity(ies) external to JCAHO that suggested the proposed changes to JCAHO; (c) all proposed changes to JCAHO standards that are modified by JCAHO as a result of comments received must provide clearly stated rationale(s) for each modified proposal, to include a clear and thorough analysis of the comment or comments upon which the modification(s) was based; and (d) all proposed changes to JCAHO standards that are adopted as final by JCAHO be published along with a clear and thorough analysis of all the field review.

3. Our AMA will ask that the new system for proposed changes to JCAHO standards be fully implemented during calendar year 2007. (BOT Action in response to referred for decision Res. 729, A-06)

D-220.976 The Relationship Between the Joint Commission on Accreditation of Healthcare Organizations and Physicians

Our AMA will:
(1) communicate to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) the concern regarding the unintended consequences of JCAHO's standards, and methods of communicating those standards to physicians;
(2) advocate with JCAHO for direct communication to physicians' organizations about standards to be adopted or modified, with at least six months available for open commentary and feedback;
(3) advocate that this communication be timely and that it occur in print media as well as through e-mail;
(4) advocate that JCAHO accreditation standards be made available to any licensed physician without hindrance;
(5) advocate that JCAHO establish a process for any physician to provide feedback about JCAHO programs that affect that physician's practice; and
(6) require that AMA JCAHO Commissioners meet with the Organized Medical Staff Section Governing Council to review JCAHO standards no less than twice per year. (Res. 817, I-06)

D-220.977 Joint Commission on Accreditation of Healthcare Organizations - Evidence-Based Recommendations

Our AMA will: (1) work with the Joint Commission on Accreditation of Healthcare Organizations to investigate the provision of a cost analysis for each new requirement; and (2) request that JCAHO provide an evidence-based evaluation to justify the expenditures for the recommendations it makes. (Res. 536, A-06)

D-220.978 JCAHO Establishment of a Certification Program for Services Provided in the Physician Office Setting Related to the Treatment of Chronic Kidney Disease

Our AMA will: (1) seek cessation of implementation of the JCAHO Chronic Kidney Disease (CKD) Advanced Certification Program for services provided in the physician's office setting but will continue to work with the JCAHO to implement clinical quality improvement programs; and (2) study the potential impact of multiple, fragmented programs of certification and accreditation related to care of patients with specific disease states and the need for advocacy of a coordinated approach to such activity to reduce redundant information requirements, costs and administrative burdens to practice sites and health professionals. (Res. 504, A-06)

D-220.979 Access to JCAHO Standards

Our AMA will: (1) commend the Joint Commission on Accreditation of Healthcare Organizations for its web site posting of FAQs (Frequently Asked Questions), clarifying the intent and application of several select standards; and (2) investigate the feasibility of disseminating the JCAHO standards as an AMA member benefit. (Res. 714, A-05)

D-220.980 JCAHO Sentinel Event Alerts

Our AMA will (1) instruct its representatives to JCAHO to express its deep concern about the scientific validity and appropriateness

of JCAHO's October 9, 2004 sentinel event alert addressing patient awareness during anesthesia; and (2) advocate to JCAHO that sentinel event alerts should not be interpreted to be equivalent to practice guidelines, given that practice guidelines should be developed and vetted by physician professional organizations, which have expertise in interpreting relevant scientific evidence regarding practice, outcomes, and safety. (Res. 827, I-04)

D-220.981 JCAHO "Do Not Use" Abbreviations

Our AMA will (1) request through the AMA representatives on the JCAHO Board that the JCAHO Board implement a moratorium on any additional "do not use" abbreviations until there is evidence of overall compliance with the currently recommended list; (2) work with the American Hospital Association to develop an acceptable interim mechanism to amend abbreviations that are legible but on the "do not use" list and to allow the continued exemption from the JCAHO standards of "do not use" abbreviations, acronyms, and symbols on dictated, transcribed, or computerized forms of clinical documentation; and (3) work with the American Hospital Association and other interested parties to create a more collaborative approach to solve the issue of use of prohibited abbreviations and to develop methods to measure compliance regarding the use of prohibited abbreviations that do not penalize hospitals or significantly increase the cost of monitoring and correcting clinician documentation. (Res. 810, I-04; Appended: Res. 731, A-05)

D-220.982 AMA Support for Physician Surveyors Consistent with AMA Policy

Our AMA will instruct its AMA Commissioners that it is their duty to advocate for positions with the JCAHO that are consistent with AMA policy. (Res. 843, I-03)

D-220.983 Provision for Conflict Resolution in Joint Commission Standards

Our AMA will work vigorously to immediately restore and expand the requirement in the Joint Commission on Accreditation of Healthcare Organizations' Hospital Accreditation Standards that the governing body or authority, and the medical staff, provide for an impartial mechanism for conflict resolution that is satisfactory to both parties. (Res. 842, I-03)

D-220.984 Use of Physicians as Surveyors in Hospital Surveys

Our AMA Commissioners on The Joint Commission will work to commit The Joint Commission:
(1) to require that surveyors in its accreditation surveys include practicing physicians wherever possible;
(2) to give priority to the hiring of physician and nurse surveyors who are no more than three years removed from their last clinical practice;
(3) to keep current records of the date of each physician and nurse surveyor's most recent clinical practice; and
(4) to enter into agreements with those state medical association independent subsidiaries that are qualified to participate in the surveys of medical staff related standards in those states which have the will and resources to do so; and our AMA will be required to follow through on the above directive. (Res. 527, A-03; Modified: Res. 843, I-03; Modified: Res. 527, A-07)

D-220.985 Enforcement of JCAHO Medical Staff Standards

Our AMA Commissioners to the Joint Commission on Accreditation of Healthcare Organizations will urge the aggressive enforcement of the Medical Staff Standards by the JCAHO to the extent that violations result in the hospital accreditation status being at risk, and our AMA will ask the JCAHO to better educate and inform medical staff and hospitals of the complaint process in place to resolve violations of the Medical Staff Standards. (Sub. Res. 528, A-03)

D-220.986 JCAHO Surveys

The AMA Commissioners to the JCAHO work to have the JCAHO oppose the inappropriate use and publication of summary grid scores. (BOT Rep. 2, I-02)

D-220.987 Pain Management Standards and Performance Measures

(1) Our AMA shall continue to work with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and encourage continued collaborative efforts between the JCAHO and relevant medical specialty organizations to clarify the JCAHO pain management standards and to identify and clarify sources of information that are contributing to misinterpretation of the standards. (2) Our AMA, with or without partnership with other Joint Commission on Accreditation of Healthcare Organizations (JCAHO) corporate members, shall appoint a committee or task force of regularly practicing health care professionals, including a multi-specialty panel of physicians, nurses and other mid-level practitioners, and administrators to objectively study and evaluate the efficacy to date of the new JCAHO Standard as it is currently being applied and identify who is responsible for its origins. This task force shall be urged to report back to the AMA Board of Trustees at an early date so that the Board can formulate recommendations to the Joint Commission. (3) The JCAHO should be encouraged to disseminate substantial additional clarification for the "examples of implementation" and eliminate them from the accreditation manuals and other publications. (CSA Rep. 4, A-02)

D-220.988 JCAHO Proposed Standard Implementation Cost and Impact

Our AMA will request the JCAHO to promulgate information from item 5 of its standards development model which states: 5. "external evaluation activities assess, when possible, benefit/costs/impact of the proposed new or revised standards. Survey process development and testing starts to determine reliability of proposed survey procedures. Formal mailing of standards documents coupled with qualitative focus group work provides information about use and usefulness of proposed standards". (Sub. Res. 805, I-01)

D-220.989 Proposed Revisions to JCAHO Medical Staff Chapter Standards

Our AMA will instruct its Commissioners to JCAHO to work to restore and ensure in the future that physicians retain their proper role and responsibility for the medical evaluation of patients, which includes the performance of an appropriate history and physical examination in order to promote patient safety and continuity of care. (Res. 828, A-00)

D-225.000 Hospitals: Medical Staff

D-225.980 Confidentiality of Medical Staff Members' Personal Proprietary Financial Information

Our AMA will: (1) seek the insertion of the term "medical staff" into the list of types of information referenced in the first sentence of the Rationale for Standard IM.2.10 in the current Joint Commission Management of Information Chapter or other appropriate language changes to provide medical staff information the same level of protection as other sensitive hospital information; (2) seek the development and adoption by the American Osteopathic Association - Health Facilities Accreditation Program (HFAP) of an accreditation standard that specifically requires policies and procedures to protect the confidentiality of personal proprietary information of medical staff members and other medical staff information; and (3) develop and promote model state legislation that will provide legal safeguards to protect the confidentiality of the personal proprietary financial information of medical staff members. (BOT Action in response to referred for decision Res. 826, I-07)

D-225.981 Marketing Low Cost Internet-Based Education Programs for Medical Staff Leadership

1. Our AMA Organized Medical Staff Section will, as appropriate, selectively offer and promote internet-based education programs on medical staff self-governance.
2. Program pricing will be determined by its cost, market place considerations and the objectives of the program (e.g., education with or without CME, promotion of AMA positions and /or policy, etc.).
3. Programs will be offered at no cost or at a discount to members. (BOT Action in response to referred for decision Res. 602, A-07)

D-225.982 Principles for Strengthening the Physician-Hospital Relationship

Our AMA will join with other physician groups in the Federation of Medicine to advocate for improved physician-hospital relationships in discussions with the American Hospital Association, The Joint Commission and the Centers for Medicare and Medicaid Services. (Res. 828, I-07)

D-225.983 Protection of Medical Staff Members' Personal Proprietary Financial Information

Our AMA will develop policy on what kind of personal proprietary information a hospital has a right to ask as part of a "conflict of interest" program and how such data should be protected and the Council on Ethical and Judicial Affairs will consider expanding Opinion E-5.07 to include the confidentiality of medical staff members' personal proprietary financial information. (Res. 22, A-07)

D-225.984 Hospitalists and the Changing Hospital Environment

Our AMA will work with the American Hospital Association, The Joint Commission, the Centers for Medicare and Medicaid Services, and the Society for Hospital Medicine to develop model guidelines on sustainable hospitalists programs. (Res. 731, A-07)

D-225.985 Preventing Elimination of Medical Staffs and Independent Peer Review Through Hospital Economic Loyalty Policies

Our AMA will vigorously seek enforcement of existing federal law and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards relating to medical staff responsibility for quality patient care, peer review and self-governance by taking the following actions:

(1) Inform the Centers for Medicare and Medicaid Services and the Department of Health and Human Services Office of the Inspector General of hospital violations of the Medicare Conditions of Participation relating to medical staff responsibilities for professional

performance and quality patient care and for medical staff participation in hospital operational and budget planning, through use of "loyalty" and "conflict" credentialing;

(2) Inquire of the US Department of Justice whether hospitals' use of "loyalty" and "conflict" credentialing, in addition to potentially violating the anti-kickback law, may also violate federal antitrust laws when it involves using market power (a) to prevent physician participation in other institutions' performance improvement programs and (b) to create barriers to competitive medical services; and

(3) Provide the JCAHO with sufficient documentation to compel it to enforce the JCAHO medical staff standards and to cite hospitals with conflict, loyalty and other policies that override the bylaws and usurp the legal responsibility of the organized medical staff. (Res. 909, I-05)

D-225.986 Blue Cross of California Quality of Care Allegations

Our AMA will reiterate its position stating that medical staffs shall not be impugned and quality of care issues not be imposed between insurance plans and hospitals as a means of addressing economic or contractual issues. (Res. 851, I-03)

D-225.987 Interference with Medical Staff Participation on Hospital Boards

Our AMA will inform the President of the Joint Commission on Accreditation of Healthcare Organizations of its concern regarding hospital board interference in medical staff participation on hospital boards, and request instruction from our AMA Commissioners to JCAHO on how to further address board interference with medical staff participation. (Res. 534, A-03)

D-225.988 Elimination of 48-Hour Signature Rule for Verbal Orders

Our AMA will: (1) urgently request issuance of final regulations on Medicare Conditions of Participation to allow hospitals and their medical staffs to establish their own policies on authentication of verbal orders; and (2) through the Organized Medical Staff Section, encourage hospital medical staffs to include policies, which consider applicable state law, on authentication of all medical record entries, including telephone and verbal orders, in their medical staff bylaws (BOT Rep. 3, A-03)

D-225.989 AMA Consultation Service for Medical Staffs

Our AMA will: (1) in concert with the Organized Medical Staff Section, continue to build relationships with local legal service providers through state medical societies to expand the number of consultants and attorneys available to address specific issues related to medical staff; and (2) continue to work with the OMSS to identify potential consultants and attorneys to be added to the ConsultingLink network, and enhance the review process that determines which of these consultants and attorneys will be added to the network. (BOT Rep. 26, A-03)

D-225.990 Medicare Payment for the Medical Direction and Supervision of Hospital-Based Clinical Laboratories

Our AMA urge the Department of Health and Human Service-Office of Inspector General to revise its Compliance Program Guidance for the Hospital Industry to state that token payment or non-payment for pathologist Part A medical direction and supervision services in exchange for Part B referrals violates the anti-kickback statute. (CMS Rep. 2, I-02)

D-225.991 AMA Consultation Service for Medical Staffs

(1) AMA Solutions develop additional criteria for screening attorneys for medical staff expertise to ensure that they have an understanding of medical staff issues and are familiar with AMA policy related to medical staff self-governance.

(2) AMA Solutions send AMA ConsultingLink applications to medical staff attorneys recommended to OMSS by state and county medical societies.

(3) The OMSS promote the AMA ConsultingLink network to its membership via e-mails and its quarterly newsletters.

(4) Our American Medical Association investigate the feasibility of creating a Consultation Service, imbued with AMA principles, policies and procedures that will be proactive in providing guidance, support, and when necessary, legal counsel for medical staffs at an affordable cost, with a report back at the 2003 Annual Meeting. (BOT Rep. 9, I-02)

D-225.992 Unilateral Medical Staff Bylaw Amendments

Our AMA Commissioners to the Joint Accreditation of Healthcare Organizations (JCAHO) shall insist that JCAHO: (1) continue to cite hospitals for unilateral amendment of medical staff bylaws, rules and regulations; and (2) cite hospitals for including provisions in their corporate bylaws that allow for the unilateral amendment of medical staff bylaws, rules and regulations, when state statutes do

not require the governing body of the hospital to have such authority. (Res. 817, A-02; Reaffirmation A-05; Reaffirmation A-06)

D-225.993 Maintaining the Medical Staff Condition in the Medicare Conditions of Participation for Hospital

Our AMA will study the impact of the revisions of the Medicare Conditions of Participation that pertain to the medical staff and report back to the House of Delegates at the 2002 Annual Meeting. (Sub. Res. 815, I-01)

D-225.994 A Physician as a Patient Safety Officer in a JCAHO Approved Health Care Facility

Our AMA will encourage medical staff physicians to take a leadership role in their hospital's patient safety activities. (Res. 803, I-00)

D-225.995 Hospital Merger Study

Our AMA will: (1) urge its AMA Commissioners to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to add a standard to the JCAHO Hospital Accreditation Standards requiring a medical staff successor-in-interest standard in the hospital medical staff bylaws;
(2) seek inclusion of medical staff bylaw successor-in-interest provisions in the Medicare Conditions of Participation and in the rules and regulations of other public and private hospital accreditation agencies;
(3) continue to monitor and report on current numbers of mergers and break-ups of mergers of hospitals in this country; and.
(4) study the impact on hospital-based physicians as a result of hospital mergers and break-ups. (CMS Rep. 7, I-00)

D-225.996 Impact of Medical Staff Development Plans and Utilization of AMA Principles for the Development of Medical Staff Development Plans

Our AMA will: (1) study the impact of medical staff development plans on physicians entering or changing practice; and delineate under what circumstances these plans may be illegal restraints of trade under the antitrust laws; and (2) report on the current utilization of the AMA Principles for the Development of Medical Staff Development Plans (Policy 225.961), with particular emphasis on the effects on hospital financial health. (Res. 801, I-99)

D-225.997 Medical Records Signature

Our AMA will take steps to implement its Policy H-225.965 as it affects the daily practices of physicians, including but not limited to getting Medicare to change the conditions of participation, and all accrediting organizations to accept this policy. (Res. 822, I-99)

D-225.998 Coerced Employment of Physicians

Our AMA will encourage the wide dissemination of Organized Medical Staff Section educational materials on physician employment contracting, including the OMSS biweekly bulletin. (CMS Rep. 4, A-99)

D-225.999 The Emerging Use of Hospitalists: Implications for Medical Education

(1)Our AMA, through its Council on Medical Education and Council on Medical Service, will collect data on the following areas: (a) the emergence of educational opportunities for hospitalist physicians at the residency level, including the curriculum of hospitalist tracks within residency training programs; (b) the availability and content of continuing medical education opportunities for hospitalist physicians; (c) the policies of hospitals and managed care organizations related to the maintenance of hospital privileges for generalist physicians who do not typically care for inpatients; and (d) the quality and costs of care associated with hospitalist practice.

(2) Our Council on Medical Education and Council on Medical Service will monitor the evolution of hospitalist programs, with the goal of identifying successful models.

(3) Our AMA will encourage dissemination of information about the education implications of the emergence of hospitalism to medical students, resident physicians, and practicing physicians. (CME Rep. 2, A-99)

D-230.000 Hospitals: Medical Staff - Credentialing and Privileges

D-230.987 Joint Commission Credentialing of Low Volume Physicians

Our AMA will study the challenges in credentialing low-volume providers and work with The Joint Commission and other interested parties to develop and utilize fair and balanced criteria and methods for credentialing such providers and procedures. (Res. 818, I-08)

D-230.988 Fiduciary Credentialing

Our AMA continues to encourage physicians who have experienced what they believe to be inappropriate hospital de-credentialing to contact their state medical association and the Litigation Center of the AMA and the State Medical Societies. (CMS Rep. 2, A-06)

D-230.989 Reappointments to the Medical Staff

Our AMA will work with the Joint Commission on Accreditation of Healthcare Organizations to change the requirement for reappointments to medical staffs to every four years. (Res. 524, A-04)

D-230.990 Inspector General to Rule on Exclusionary Credentialing

Our AMA will (1) press the US Department of Health and Human Services, Office of the Inspector General to rule on whether exclusive credentialing as practiced by some hospitals/health care institutions constitutes violation of fraud and abuse laws and regulations; and (2) communicate physicians' ire over the inordinate delay by the Office of the Inspector General in addressing the exclusive credentialing issue. (Res. 201, A-04)

D-230.991 Inspector General to Rule on Exclusivity Restrictions for Medical Staff Membership

Our AMA will (1) continue its discussions with the Office of Inspector General of Health and Human Services and urge the OIG to issue a fraud alert on the practice of exclusive credentialing; and (2) take other appropriate action, which may include administrative action, litigation, and/or legislation, to protect our patients from being denied quality medical care through exclusive (including economic) credentialing by hospitals. (Res. 714, I-02)

D-230.992 Hospital Medical Staff Privileges

Our AMA shall continue to actively communicate with the American Hospital Association to promote our AMA's current policies concerning hospital privileges. (Res. 813, A-02)

D-230.993 Applying Pressure on DHHS Office of Inspector General for Resolution of Economic Credentialing Issue

(1) Our AMA shall continue to work with OIG to develop a fraud alert on economic credentialing. (2) Our AMA shall continue to provide examples of economic credentialing practices and policies to OIG staff. (3) The Board of Trustees shall report back at the 2002 Interim Meeting on work with the OIG and its review of economic credentialing practices. (BOT Rep. 15, A-02)

D-230.994 Applying Pressure on Department of Health and Human Services Office of Inspector General to Rule on Hospital-Imposed Exclusivity Restrictions, as a Form of Economic Credentialing, for Medical Staff Membership

Our AMA continue to aggressively seek resolution with the Department of Health and Human Services Office of Inspector General of the issues of alleged fraud and abuse associated with hospital-imposed exclusivity policies as a form of economic credentialing and that the Board of Trustees report back at the 2002 Annual Meeting. (Res. 812, I-01)

D-230.995 Universal Credentials Application

Our AMA will develop and strongly advocate the use of a standardized credentials application form that would be available to all hospitals and insurance plans. (Res. 709, I-01)

D-230.996 Managed Care Provisional Credentialing

(1) Our AMA will urgently request the CMS to change any existing regulations which preclude the provisional credentialing of newly trained physicians. (2) Should CMS not comply with changing any regulations precluding provisional credentialing, our AMA prepare and seek introduction of Federal legislation to accomplish the necessary changes. (3) Our AMA will demand appropriate and expeditious (within 60 days) credentialing by Medicare, Medicaid and managed care organizations of established physicians whose practices relocate, merge or otherwise change their status. (Res. 808, I-00)

D-230.997 Economic Loyalty Criteria for Medical Staff Privileges

Our AMA will: (1) strongly oppose the implementation of economic loyalty criteria; (2) draft model legislation for dissemination to the Federation, that would prohibit the implementation of economic loyalty criteria; and (3) notify the American Hospital Association and other hospital associations of AMA policy opposing economic loyalty criteria. (Res. 804, I-00; Reaffirmation A-05)

D-230.998 Provisional Credentialing of Newly Trained Physicians for MCO Networks

Our AMA will work with the National Committee for Quality Assurance (NCQA) to establish guidelines for the provisional

credentialing of newly trained physicians and relocation of established physicians for Managed Care Organization (MCO) networks within their accreditation standard for physician credentialing. (Res. 307, I-99)

D-230.999 Facilitating Entry into Practice

Our AMA: (1) will encourage residency program directors to send letters, on request, stating the resident's satisfactory progress in the residency to date and an expected graduation date, that will help assist a resident to meet credentialing requirements; (2) will work through the American Board of Medical Specialties and the Federation of State Medical Boards to encourage timely notification of board certification results and medical licensure status; and (3) as a matter of urgency, will work with all relevant entities to establish mechanisms for provisional credentialing of newly trained physicians and to facilitate the relocation of established physicians. (Sub. Res. 301, I-99)

D-235.000 Hospitals: Medical Staff - Organization

D-235.989 Strengthening Medicare Requirements on Self-Governance

Our AMA will take all appropriate steps to (1) seek federal regulatory and/or statutory changes to strengthen a medical staff's right to self-governance to ensure that the medical staff as a whole is responsible for the patient care, patient safety, and the quality of care delivered in the hospital; (2) seek federal statutory and/or regulatory changes as necessary to ensure that the Medicare program has the ability to, and does in fact, enforce Medicare conditions of participation relating to the organized medical staff. (Res. 840, I-08)

D-235.990 JCAHO Standard MS.1.20

Our AMA Commissioners to the Joint Commission:
(1) introduce and support language before the full JCAHO board such that Standard MS.1.20 clearly states there is a single document known as the "Medical Staff Bylaws" which must be approved by the voting members of the medical staff;
(2) introduce and support language before the full JCAHO board such that JCAHO Standard MS.1.20 clearly states that the following components are to be an integral part of the medical staff bylaws:
a. Application, reapplication, credentialing and privileging
b. Fair hearing and appeal processes
c. Selection, election and removal of medical staff officers
d. The clinical criteria and standards which manage quality assurance and improvement, and utilization review
e. Criteria and processing for privileging
f. Qualification for appointment
g. The structure of the medical staff
h. The duties and privileges of medical staff categories
i. The right to develop and adopt medical staff policies, procedures, rules, and regulations
j. The right and ability of the medical staff as a group to retain and be represented by independent legal counsel at the medical staff's expense
k. The right and ability to assess dues and to utilize the dues as the medical staff sees fit; and
(3) continue to advocate:
a. Any element of performance of Standard MS.1.20 must be retained in the medical staff bylaws and not in other documents such as rules and regulations or policies
b. The hospital governing body cannot unreasonably withhold approval of the medical staff bylaws
c. The medical staff bylaws require self-governance by the medical staff
d. That the medical staff, through their bylaws, shall determine which rules and regulations shall require approval by a vote of the medical staff, and that the medical staff develop a mechanism for periodic review of all new rules and regulations, and, upon challenge, a mechanism for a vote thereon by voting members of the medical staff (Res. 831, I-06; Reaffirmed and Modified: BOT action in response to referred for decision Res. 728, A-08 and Res. 730, A-08)

D-235.991 Medical Staff Standard MS 1.40, Element of Performance 8

Our AMA, through the AMA Commissioners to the Joint Commission on Accreditation of Healthcare Organizations, will urge amendment of medical staff Standard MS.1.40, Element of Performance 8, to read as follows:

The medical staff shall develop criteria regarding medical staff structure within the medical staff bylaws. These criteria will be presented for ratification to the governing body, and such ratification shall not be unreasonably withheld. (Res. 711, A-05)

D-235.992 JCAHO Standard MS 1.20 and Element of Performance 19

Our AMA Commissioners to JCAHO will petition JCAHO to move up the timetable for implementation of MS.1.20, EP 19. (Res. 730, A-05)

D-235.993 Medical Staff Bylaws as a Contract

Our AMA:

(1) Advocacy Resource Center will work with state and specialty societies to draft and support legislation to establish medical staff bylaws as a contract;

(2) Advocacy Resource Center will work with state and specialty societies to draft and support legislation to require that due process protections for termination of staff privileges be included in all medical staff bylaws;

(3) will work to have JCAHO require due process protections in medical staff bylaws as part of the JCAHO accreditation process; and

(4) will take into consideration the analysis presented in Board of Trustees Report 9 (I-04) in the proposed model legislation referred to above. (BOT Rep. 9, I-04)

D-235.994 Medical Staff Autonomy and Self-Governance

Our AMA will:
(1) support the autonomy of hospital medical staffs with respect to hospital boards in order that the work of the medical staff can proceed uninterrupted to maintain quality of care within the institution;
(2) encourage national legislation that would strengthen the rights of the hospital medical staff to self-governance; and
(3) seek federal legislation which would prohibit unilateral changes in hospital medical staff bylaws, rules and regulations or policy/procedures manuals, unless required by law. (Res. 523, A-04)

D-235.995 Physicians' Guide to Medical Staff Organization Bylaws

Our AMA's Office of the General Counsel will develop a third edition of the Physicians' Guide to Medical Staff Organization Bylaws immediately, it will be made immediately available in an electronic format for AMA members as soon as possible, and it will be updated every two years, or more frequently as needed. (Res. 536, A-04)

D-235.996 Preservation of Medical Staff Self-Governance

Our AMA will request the Litigation Center of the AMA consider providing assistance for appropriate cases regarding the protection of medical staff self-governance. (Sub. Res. 614, A-03)

D-235.997 Hospital Medical Staff-Governance

Our Board of Trustees will study the feasibility and costs of implementing items (a) and (b) which follow, and determine if there are other tools currently in existence that would alleviate the need for such action and report back at A-02:

(a) Our AMA, in coordination with state medical societies, will take steps to educate medical staffs on AMA policy regarding medical staff self-governance and advise medical staffs to proceed cautiously when engaging the services of organizations or consultants that propose to amend medical staff bylaws in ways that are contrary to medical staff self-governance. (b) Our AMA develop, with input from its Organized Medical Staff Section Governing Council, in conjunction with state medical societies, a comprehensive guide for medical staff bylaws and other tools to assist physicians in performing the duties and responsibilities associated with medical staff self-governance. All medical staff resources will be consistent with AMA policies on medical staff self-governance. (Sub. Res. 817, I-01)

D-235.998 Medical Staff Legal Status, Legal Counsel and Conflict of Interest

(1) BOT Report 3, A-99 be transmitted to the American Bar Association and widely disseminated to the chiefs of staff of hospital medical staff and chairs of hospital medical staff bylaws committees and AMA members. (2) Our AMA provides information on how to report attorneys who have not appropriately disclosed their conflict of interest to their Bar Association (BOT Rep. 3, A-99)

D-240.000 Hospitals: Reimbursement
(See also: Hospitals; Hospitals: Accreditation Standards; Hospitals: Medical Staff; Hospitals: Medical Staff - Credentialing and Privileges; Hospitals: Medical Staff - Organization)

D-240.995 Patients Admitted for Observation

Our AMA will promote the application of criteria that are established by scientific evidence, based on good clinical practice for

admission to hospitals. (BOT Action in response to referred for decision Res. 715, I-07)

D-240.996 Establishing a Medicare Ambulatory Payment Classification for Hospital Observation Status

Our AMA will continue to work with CMS to develop and implement an ambulatory payment classification (APC) for payment for patients placed in observation status. (BOT Action in response to referred for decision Res. 823, I-00)

D-240.997 New DRG for Severe Sepsis

Our AMA will submit a response to the Centers for Medicare & Medicaid Services during the public comment period urging the CMS to explicitly recognize severe sepsis as a clinically coherent condition associated with a high mortality, and a patient population displaying similar characteristics in terms of outcome and costs incurred for treatment, thereby deserving its own DRG. (Res. 133, A-04)

D-240.998 Outpatient Prospective Payment System

Our AMA will: (1) actively seek to reverse the recent Medicare pro-rata reduction in Outpatient Prospective Payment System pass-through payments in order to ensure that our patients have full access to best health care available in the outpatient setting; (2) work with the Centers for Medicare and Medicaid Services to find methods to collect current, accurate, appropriate therapy cost data to provide adequate reimbursement for the cost of technology under the APC categories with technology components, that are improving patient care in the outpatient setting; and (3) urge CMS to establish a process by which physician specialty societies may have an opportunity to work with CMS to review and refine costs in the hospital outpatient setting. (Res. 113, I-01; Reaffirmed, A-03; Reaffirmation A-06)

D-240.999 Hospital Length of Stay

Our AMA will continue to work with all entities involved to adopt this uniform definition. (Res. 709, A-00)

D-245.000 Infant Health

D-245.995 Support of Sudden Infant Death Syndrome (SIDS) Research

Our AMA will advocate for research into SIDS and encourage medical examiners and coroners to collect tissue samples for research purposes from infants who have died suddenly and unexpectedly, to the extent permissible by law. (Res. 520, A-07)

D-245.996 Standardization of Newborn Screening Programs

Our AMA will monitor developments in the effort to implement a uniform minimum newborn screening panel, including status of the pending Health Resources and Services Administration report entitled *Newborn Screening: Toward a Uniform Screening Panel and System*, and the ongoing expansion of required tests by each state. (CSAPH Rep. 9, A-06)

D-245.997 Promotion by Physicians and Hospitals of Breastfeeding

Our AMA will investigate the factors contributing to the differences in breastfeeding rates between various racial and ethnic groups with a report back that includes possible actions to be taken to address these factors. (Res. 412, A-04)

D-245.998 Protecting a Mother's Right to Breastfeed

Our AMA shall widely disseminate its model legislation that supports and protects a mother's right to breastfeed in public and encourage all states to pass legislation that clarifies and protects a mother's right to breastfeed in public. (Res. 216, A-02)

D-245.999 SIDS and Autopsy

Our AMA: (1) shall educate all physicians that the diagnosis of Sudden Infant Death Syndrome is a diagnosis of exclusion and should not be made without the assistance of an autopsy; and (2) Council on Legislation shall review the American Academy of Pediatrics model Child Death Investigation Act and, if appropriate, disseminate it to the Federation. (Res. 201, A-02)

D-250.000 International Health

D-250.989 Support of the Nightingale Declaration for a Healthy World by 2020

Our AMA and its state and component societies encourage their members to support the Nightingale Initiative for Global Health, and

sign the Nightingale Declaration for a Healthy World by 2020. (Res. 422, A-07)

D-250.990 Israeli Medical Association

Our AMA will oppose any efforts to expel the Israeli Medical Association from the World Medical Association. (Res. 613, A-07)

D-250.991 Victims of the War in Kosovo

Our AMA will continue to support: (1) the efforts of the AMA Office of International Medicine in its role as a clearinghouse for volunteer relief efforts through our web site; and (2) monitoring of human rights issues related to health care personnel, appropriately enlisting the Federation network to respond through letter-writing campaigns. (BOT Action in response to referred for decision Res. 620, A-99)

D-250.992 Medical Supply Donations to Foreign Countries

Our AMA will: (1) continue to advertise opportunities for donations on the AMA web site and continue to refer individual physicians to appropriate relief agencies; and (2) continue current relationships with relief organizations. (BOT Action in response to referred for decision Res. 608, A-99)

D-250.993 Support the Measles Initiative

Our AMA will take reasonable measures to make physicians aware of the World Health Organization's global initiative to bring measles deaths to near zero in Africa by 2005 by vaccinating 200 million children and encouraging them to support it. (Res. 416, A-05)

D-250.994 United Nations Population Fund

Our AMA will:
(1) support reinstitution of US funding to the United Nations Fund for Population Activities or other United Nations population and reproductive health programs consistent with AMA policy;
(2) write letters to the Bush Administration and to the US House of Representatives expressing concern over the withdrawal of United States funding from the United Nations Fund for Population Activities and recommending full reinstitution of such funding; and
(3) educate its members about the possible consequences of the withdrawal of US funding from the United Nations Fund for Population Activities and its support for the reinstitution of such funding. (Res. 441, A-04)

D-250.996 Outreach to the Iraqi Medical Community

Our AMA will actively encourage the Federation's medical societies to reach out to their counterpart societies in Iraq with diplomacy and resources. (Res. 222, A-03)

D-250.997 Post-War Medical Volunteers and Supplies

Our AMA will: (1) communicate with federal agencies about the physician specialties it represents, the interest of physicians to provide aid to Iraq, and our AMA's capabilities to assist in rebuilding Iraq's health care system with workforce, teaching, supplies and equipment, and (2) work with federal agencies coordinating relief and reconstruction and serve as a liaison between such agencies and societies represented in our AMA that want to provide assistance in Iraq. (Res. 216, A-03)

D-250.998 International Medical Volunteers

Our AMA, using its existing infrastructure and within current resources, will support the efforts of international and domestic medical volunteer endeavors such as the International Health Volunteers Organization and encourage their development. (Res. 606, A-03)

D-255.000 International Medical Graduates

D-255.982 Oppose Discrimination in Residency Selection Based on International Medical Graduate Status

Our AMA:

1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.

2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.

3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms. (Sub. Res. 305, A-08)

D-255.983 Observerships for International Medical Graduates

Our AMA will, through its relevant Sections, work with internal and external groups to develop guidelines for observership programs for International Medical Graduates (IMGs) who have received certification by the Educational Commission for Foreign Medical Graduates, including the following: (a) development of a set of educational objectives and a model curriculum outline; and (b) identification of educational/informational materials to address the objectives; and (c) creation of informational materials related to legal, organizational, and operational issues related to program implementation. (CME Rep. 12, A-08)

D-255.984 Expedite the Immigrant Visa Process for Physicians

Our AMA will lobby Congress and the federal government to exempt physicians with H-1B Visas who fulfilled their J-1 Visa waiver requirements from any immigration caps. (Res. 234, A-06)

D-255.985 Conrad 30 - J-1 Visa Waivers

Our AMA will: (1) lobby for the reauthorization of the Conrad 30 J-1 Visa waiver program; and (2) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state. (Res. 233, A-06)

D-255.986 Practice of Not Granting Appropriate Visas to International Medical Graduates

Our AMA will request that the State Department expedite granting of otherwise appropriate visas to International Medical Graduates who pass United States Medical Licensing Exams. (Res. 232, A-06)

D-255.987 J-1 Visa Service Requirement

Our AMA will lobby the US Department of State to change the current J-1 Visa waiver policy to allow for exceptions on a "case-by-case" basis where the continuous service requirement can be waived, such as in cases of documented abusive and intolerable employment conditions. (BOT Rep. 11, A-06)

D-255.988 J-1 Visa Waiver Application

Our AMA will lobby the relevant federal agencies to process the paperwork for J-1 Visa waivers expeditiously. (Res. 712, I-05)

D-255.989 Expeditious Security Clearance and Visa Processing of Physicians

Our AMA will:

(1) lobby the relevant federal agencies to process J-1 and B-1 visa applications and security clearances more expeditiously for IMGs already accepted into residency programs than those in the general pool of visa applicants;

(2) lobby the relevant federal agencies to issue J-1 visas to IMGs for the entire duration of their residency program up to a maximum of 7 years; and

(3) urge federal agencies and residency programs not to discriminate against any IMGs, particularly those from Pakistan. (Res. 236, A-05)

D-255.990 Nondiscrimination in Residency Selection

Policy H-255.983 will be communicated to the Accreditation Council for Graduate Medical Education and to all residency program directors. (Sub. Res. 314, A-04)

D-255.991 Visa Complications for IMGs in GME

Our AMA will: (1) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice;

(2) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and

(3) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. (Res. 844, I-03)

D-255.992 Opposition to Employment of Non-certified International Medical Graduates

Our AMA, in conjunction with the California Medical Association, will recommend to the California legislature and the California Hispanic Healthcare Association, other solutions to the California physician shortage including (1) maximizing their use of existing programs such as the National Health Service Corps and the J-1 visa waiver program, and (2) recruiting Spanish-speaking physicians who have recently retired by assisting them with state licensing and liability concerns.

Our AMA, in conjunction with state medical societies, will respond to attempts by states to employ non-certified physicians for patient care by recommending solutions to those states such as (1) maximizing their use of existing programs such as the National Health Service Corps and the J-1 visa waiver program, and (2) recruiting physicians who have recently retired by assisting them with state licensing and liability concerns. (Res. 320, A-03)

D-255.993 J-1 Visas and Waivers

(1) The AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program. (2) If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program. (3) The AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03. (BOT Rep. 11, I-02)

D-255.994 Report on the Fifth Pathway

(1) The "Fifth Pathway Statement" (2001 revision) be disseminated to existing and developing programs, prospective students, and others on request and that adherence to its requirements continue to be monitored. (2) Our AMA will explore ways to collect and disseminate information on the general outcomes of the Fifth Pathway, including such things as graduate specialty choice, performance in residency training, board certification status, and record of disciplinary actions. (CME Rep. 2, I-01)

D-255.995 Discrimination Against IMGs in Classified Advertising

Our AMA will strongly encourage medical journals not to accept advertising that violates the nondiscrimination standard established in our AMA Bylaws § 1.50. (Sub. Res. 604, A-00)

D-255.996 ECFMG Representation

Our AMA will strongly encourage the ECFMG to regularly appoint an international medical graduate as one of the at-large members on its Board of Trustees. (Res. 304, A-00)

D-255.997 Alternate Licensure Protocols for IMGs

Our AMA will actively support the Florida Medical Association in pursuing legislation that would require the Florida Department of Health to prevent and negate separate criteria for International Medical Graduates to become licensed as Florida physicians. (Res. 311, A-00)

D-260.000 Laboratories

D-260.995 Improvements to Reporting of Clinical Laboratory Results

Our AMA will: (1) continue its involvement with the Health Information Technology Standards Panel's Electronic Health Record Technical Committee that is developing a process through which laboratory results can be communicated electronically; and (2) become involved in and/or provide input in the appropriate initiatives developing electronic standards and implementation guides for the electronic transmission of clinical laboratory results. (BOT Rep. 16, I-06)

D-260.996 Improvements to Reporting of Clinical Laboratory Results

Our AMA will work with the appropriate specialty societies and laboratories in the United States for continued improvements in the reporting of clinical laboratory results with a report back to the House of Delegates at the 2006 Interim Meeting. (Sub. Res. 806, I-05)

D-260.997 Retain CLIA Cytology PT Program as Educational

Our AMA will advocate to the relevant government agencies that the cytology proficiency testing program, a long dormant provision of the Clinical Laboratory Improvement Amendments of 1988 that began implementation in 2005, remain as an educational pilot program at least through 2007 or until such time as the Clinical Laboratory Improvement Advisory Committee can review the scientific data and provide an opinion on the validity of the grading criteria, the clinical relevance of the grading criteria, the importance of using field validated Pap test slides, and the need for a testing frequency of once a year. (Res. 526, A-05)

D-260.998 Reimbursement for Clinical Lab Work

Our AMA will study the issues and problems in implementing the above policy with a report back at I-2002. (Res. 107, I-01)

D-260.999 Laboratory Testing Panels

Our AMA will study the cost effectiveness of reporting all abnormal test results generated by an automated testing procedure to the physician regardless of the individual test ordered. (Res. 523, A-99)

D-265.000 Legal Medicine
(See also: Crime; Prisons)

D-265.990 Strategic Lawsuits Against Public Participation (SLAPP)

Our AMA will make available, but not as a matter of advocacy priority, model anti-SLAPP legislation protecting physicians' First Amendment rights in the context of proceedings relating to quality of health care. (BOT Action in response to referred for decision Res. 832, I-05)

D-265.991 Pilot Program on Independent Experts and Testimony in Civil Cases

Our American Medical Association (1) applauds the expert witness pilot program established by the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association that addresses issues surrounding the admissibility of expert testimony in civil cases and the ability of a trial judge to call an independent expert; and (2) will monitor the progress of the expert witness pilot program established by the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association and report to the House of Delegates. (Res. 2, I-05)

D-265.992 Threats Against Physicians Based on Americans with Disabilities Act

Our AMA will investigate the problem of physicians being harassed with the threat of a lawsuit based upon a non-meritorious claim using the Americans with Disabilities Act as the basis for the claim and, if found to be a problem, create a corrective action plan to deal with this abuse. (Res. 207, A-05)

D-265.993 Expert Witness in Medical Liability Issues: Qualifications and Code of Conduct

1. Our AMA will develop model state legislation that would adopt standards similar to Federal Rule of Civil Procedure 26(a)(2)(B) applicable to experts testifying in medical liability cases in state court.

2. The AMA's Expert Witness Affirmation Statement will be posted on the AMA web site. (BOT Rep. 8, I-04)

D-265.994 Expert Witness Affirmation

Our AMA will (1) develop an expert witness affirmation with the collaborative and active involvement of national specialty societies (particularly those that already have expert witness affirmations) and state medical societies and work with specialty societies and state medical societies to identify mechanisms for reporting unethical testimony and develop common standards for responding to reports of unethical testimony; and (2) present this expert witness affirmation to the House of Delegates at the 2004 Interim Meeting for consideration and adoption. (Res. 7, A-04)

D-265.995 Physician Testimony Related to Tobacco and Health

The AMA will: (1) urge that persons who suspect that a physician has misstated his or her credentials or has not testified honestly and truthfully in matters that concern tobacco as related to health should report such information in writing to the AMA Office of General Counsel, as indicated in this report; and (2) respond to such information in the manner indicated in this report. (BOT Rep. 35, A-03)

D-265.996 CIGNA Settlement

Our American Medical Association state unequivocally and publicize that it has taken no official position in regard to the case entitled Kaiser v. CIGNA et al or in regard to the Settlement Agreement in that case. (Sub. Res. 823, I-02)

D-265.997 False Testimony

Our AMA shall explore the feasibility of all specialty societies establishing a registry for all depositions and testimony given by any one of its members and, if determined to be feasible, encourage all specialty societies to develop such a registry. (BOT Rep. 32, A-02)

D-265.998 Medical Care Online

Our AMA will continue to examine the legal issues associated with medical care online and make the results of this examination available to physicians. (CMS Rep. 4, A-01)

D-265.999 The Right to Know Your Accuser

Our AMA will institute all possible measures on a national level to allow physicians who are subjected to investigations by federal agencies to know their accusers. (Resolution 220, A-01)

D-270.000 Legislation and Regulation

D-270.989 Improvements to the Maintenance of Certification Process

By September 15, 2008, our AMA Board of Trustees will write a letter to the American Board of Medical Specialties (ABMS) asking that it work with its 24 member boards to:

a. coordinate with each other, the ABMS, specialty societies and the AMA to ensure that the demands of Maintenance of Certification (MOC) are reasonable;
b. educate physicians and increase their understanding of the MOC process and its requirements;
c. solicit physician input and feedback regarding MOC implementation;
d. make transparent all recertification-related costs;
e. work to minimize the disruption of physician practice due to MOC requirements; and
f. ensure that the number of MOC-related testing dates and the locations of testing sites are ample enough to minimize the burden on physician practices and their time away from clinical care. (Res. 323, A-08)

D-270.990 Diagnosis of Disease and Diagnostic Interpretation of Tests Constitutes Practice of Medicine to be Performed by or Under the Supervision of Licensed Physicians

Our AMA will pursue all appropriate legislative, regulatory and legal actions to counter expansions of the scope of work by PhD clinical lab scientists and other non-physician laboratory personnel to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine. (Res. 904, I-06)

D-270.991 Repeal of Contact Lens Law

Our AMA will call for amendment of the Federal Fairness to Contact Lens Consumer Act (PL 108-164) to remove the passive verification subsection, which requires a physician who has issued a prescription for a contact lens to respond to a dispensing entity within eight hours. (Res. 540, A-06)

D-270.992 Support for Inflammatory Bowel Disease Bill (HR 290/S. 491)

The AMA does not support H.R. 290/S. 491, the “Inflammatory Bowel Disease Act,” at this time. (BOT Action in response to referred for decision Res. 914, I-03)

D-270.993 Support for the Screen for Life Bill (HR 1422/S. 740) to Increase Screening for Colorectal Cancer

Our AMA does not support H.R. 1422/S. 740, the "Colon Cancer Screen for Life Act." (BOT Action in response to referred for decision Res. 913, I-03)

D-270.994 Universal Out-of-Hospital DNR Systems

Our AMA will seek greater standardization and reciprocity among states of DNR and AD-DNR legislation, and AMA model legislation "An Act Concerning Out-of-Hospital Do-Not-Resuscitate Orders," will be widely disseminated and submitted to the National Conference of Commissioners on Uniform State Laws. (CEJA Rep. 6, A-05)

D-270.995 Physician Ownership and Referral for Imaging Services

Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services. (Res. 235, A-04; Reaffirmed in lieu of Res. 901, I-05)

D-270.996 Modification for Pending Federal Bankruptcy Legislation

Our AMA will immediately: (1) pursue all avenues available to correct the problems with the Bankruptcy Reform Act of 2001 that pertain to asset protection plans, bankruptcy, homestead exemptions, pension and retirement plans and any other provisions of this Act that adversely affect physicians; and (2) communicate to its members the importance of contacting their Senators and Representative to urge them to correct the problems with the Bankruptcy Reform Act of 2001 that adversely affect physicians. (Res. 247, A-01)

D-270.997 Increased Funding for Physician Training and Reimbursement for Health Care of Mentally Retarded/Developmentally Disabled (MRDD) Individuals

Our AMA seek legislation increasing the: (1) funds available for training physicians in the care of mentally retarded/developmentally disabled (MRDD) individuals, and increasing the reimbursement for the health care of these individuals; and (2) insurance industry and government reimbursement to reflect the true cost of health care of mentally retarded/developmentally disabled (MRDD) individuals. (Res. 237, A-01)

D-270.998 Oppose Scope of Limited English Proficiency Guidance

Our AMA BOT, to the fullest extent appropriate, will authorize further efforts necessary to actively oppose the inappropriate extension of the Limited English Proficiency Guidance issued by the US Department of Health and Human Services' Office of Civil Rights' to physicians in private practice. (Res. 216, I-00)

D-275.000 Licensure and Discipline

D-275.964 Principles of Due Process for Medical License Complaints

Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians' rights. (Res. 238, A-08)

D-275.965 Optional Use of Social Security Numbers During the Council for Affordable Quality Health Care Credentialing Process

Our AMA will advocate for the Council for Affordable Quality Healthcare to make Social Security Numbers an optional field in their on-line provider credentialing application. (Res. 715, A-08)

D-275.966 Eliminating Disparities in Licensure for IMG Physicians

Our AMA will advocate and assist the state medical societies to seek legislative action eliminating any disparity in the years of graduate medical education training required for full and unrestricted licensure between IMG and LCME graduates. (Res. 327, A-08)

D-275.967 Telemedicine and Medical Licensure

Our AMA will work with the Federation of State Medical Boards to study how guidelines regulating medical licenses are affected by telemedicine and medical technological innovations that allow for physicians to practice outside their states of licensure. (Res. 317, A-08)

D-275.968 Independent Regulation of Physician Licensing Exams

Our AMA will study potential mechanisms of independent oversight regulation of the creation, implementation and regulation of physician licensing exams, with report back at the 2008 Annual Meeting. (Res. 301, A-07)

D-275.969 Specialty Board Certification and Recertification

1. Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research findings on the issues surrounding certification, recertification and MOC on a periodic basis.

2. An update report will be prepared for the AMA House of Delegates no later than 2010.

3. Our AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care.

4. Our AMA will exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07)

D-275.970 Needle Electromyography

Our AMA affirms that performing needle electromyography is the practice of medicine, and will work to discourage: (1) other non-physician health care professionals from expanding their scope of practice to include performing needle electromyography; and (2) physicians from preparing reports and submitting claims on needle electromyographic studies that they did not perform or personally supervise. (Res. 711, A-06)

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

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. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07)

D-275.972 Spoken English Proficiency Component of the United States Medical Licensing Examination

Our AMA will take no action to request the elimination of the Spoken English Proficiency score from the USMLE Step 2 CS. (CME Rep. 8, A-06)

D-275.973 Essentials for Approval of Examining Boards in Medical Specialties

Our AMA approves the twelfth revision of the Essentials for the Approval of Examining Boards in Medical Specialties. (CME Rep. 1, I-05)

D-275.974 Depression and Physician Licensure

Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing. (Res. 319, A-05)

D-275.975 Sharing of Medical Disciplinary Data Among Nations

Our AMA will, in conjunction with the Federation of State Medical Boards, support the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of information among medical regulatory authorities worldwide. (Res. 318, A-05)

D-275.976 Arbitrary Exclusion of International Medical Schools Which Impacts Physician Licensure

Our AMA will, in close consultation with its IMG Section, work with the Federation of State Medical Boards in its current efforts to study methods to evaluate international medical schools for licensure of their graduates. (Res. 310, A-05)

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

Our AMA will:

(1) continue to monitor the progress of Maintenance of Certification (MOC) and its ultimate impact on the practice community;

(2) encourage the Physician Consortium for Performance Improvement, the American Board of Medical Specialties, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC; and

(3) encourage the ABMS Maintenance of Certification Task Force to develop and adopt recommendations for re-entry into clinical practice and entry into Step IV of MOC for diplomates not involved in direct patient care. (CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07)

D-275.978 Initial State Licensure

Our AMA will work with the Federation of State Medical Boards, state medical societies, state medical boards, and state legislatures, to eliminate the additional graduate medical education requirements imposed on IMGs for an unrestricted license, in the earnest hope of implementing AMA Policy H-275.985. (Res. 831, I-04)

D-275.979 Non-Physician "Fellowship" Programs

Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients. (CME Rep. 4, I-04)

D-275.980 Simplifying the State Medical Licensure Process

Our AMA Board of Trustees will assign appropriate individuals from within the AMA to work with the Federation of State Medical Boards and keep the AMA membership apprised of the FSMB's actions on developing a standardized medical licensure application, and the individuals assigned by the AMA Board of Trustees regarding the FSMB's work on standardized medical licensure application will report back to the AMA on a yearly basis beginning at the 2005 Annual Meeting, until decided by the Board of Trustees that this is no longer necessary. (Res. 324, A-04)

D-275.981 Potential Impact of the USMLE Step 2 CS and COMPLEX-PE on Undergraduate and Graduate Medical Education

Our AMA will: (1) continue to closely monitor the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; (2) inform residency program directors of the potential impact of the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE by distributing copies of this report to all program directors; and (3) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. (CME Rep. 4, A-04)

D-275.982 Rational Role for USMLE Step Exams

Our AMA will work with the National Board of Medical Examiners and the Federation of State Medical Boards to implement the recommendations in Policy H-275.953. (CME Rep. 3, A-04)

D-275.983 Physicians' Right to Reasonable Privacy Protection and the Federation Credentials Verification Service

Our AMA will request the Federation Credentials Verification Service (FCVS) to (1) add to its "Affidavit and Release" and "Authorization for Release of Records" forms appropriate language that: (a) allows physicians to revoke a prior authorization to the FCVS at any time through an affirmative action on the part of the physician (e.g., written notice) and (b) informs physicians their authorization will remain in effect unless and until revoked by the physician in accordance with guidance provided by the FCVS; and (2) clarify its release does not extend to liability which arises from the gross negligence or willful misconduct of FCVS. (BOT Rep. 22, A-04)

D-275.984 Licensure and Liability for Senior Physician Volunteers

Our AMA (1) and its Senior Physician Group will inform physicians about special state licensing regulations for volunteer physicians; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the sharing of model state legislation, to establish special reduced-fee volunteer medical license for those who wish to volunteer their services to the uninsured or indigent. (BOT Rep. 17, A-04)

D-275.985 Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation

Our AMA will: (1) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME);

(2) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE;

(3) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first five years after the implementation of the proposed exam;

(4) in conjunction with the National Resident Matching Program, the American Osteopathic Association, the Accreditation Council for Graduate Medical Education, and other interested organizations, study the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education and report back at the 2004 Annual Meeting;

(5) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the proposed CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 60 days;

(6) monitor in an ongoing fashion, the proposed implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum; and

(7) involve all interested groups at the AMA in any AMA deliberations regarding the CSAE as well as utilization of this or a similar test for recertification purposes, to ensure that the perspectives of all physicians are reflected. (Res. 324, A-03)

D-275.986 Developing Rational Role for USMLE Step Exams

Our American Medical Association, with appropriate partners, will study what role, if any, scaled and scored national, standardized examinations like the USMLE Steps I and II should have in evaluation of applicants for residency, and propose appropriate changes to the examination(s) in order to serve that role. (Res. 303, A-03)

D-275.987 Internal Medicine Board Certification Report - Interim Report

Our AMA shall: (1) support the ACP/ASIM in its efforts to work with the American Board of Internal Medicine (ABIM) to improve the Maintenance of Certification (MOC) program;

(2) encourage specialty societies to work with their respective ABMS member board to develop, implement and evaluate the Maintenance of Certification (MOC) program;

(3) continue to assist physicians in practice performance improvement;

(4) continue to monitor the progress by the American Board of Internal Medicine and the other member boards of the American Board of Medical Specialties (ABMS) on implementing the Maintenance of Certification (MOC) program;

(5) encourage the ABMS to include practicing physicians and physicians with time limited board certificates to assist in designing and evaluating the Maintenance of Certification (MOC) process for each of the ABMS member boards; and

(6) shall study the ethical implications of the Maintenance of Certification (MOC) program including the patient assessment component vis-à-vis the doctor-patient relationship and the ethical implications of the peer review component vis-à-vis the practice environment. (CMS Rep. 7, A-02; Reaffirmed: CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07)

D-275.988 USMLE - Feedback On Failing Scores

(1) The NBME and the FSMB be encouraged to continue the level of individualized feedback currently provided to all candidates for all steps of the USMLE and investigate opportunities to provide more detailed information that would not compromise the integrity of the examinations.

(2) The ABMS be encouraged to request its member boards that do not provide "In-Training" examinations to develop such tools

independently or in conjunction with an appropriate specialty society so as to maintain a level of consistency in opportunities to prepare for certification examinations.

(3) The ABMS be encouraged to request its member boards that do not provide content outlines of examinations to candidates to make such information available.

(4) The ABMS be encouraged to investigate the feasibility of providing some level of individualized feedback for less than satisfactory performances on all certification examinations. (CME Rep. 5, A-02)

D-275.989 Credentialing Issues

Our AMA shall: (1) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (2) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials. (CME Rep. 3, A-02)

D-275.990 Implementation of NBME Clinical Skills Assessment Exam

Our AMA will: (1) request an itemized rationalization from the National Board of Medical Examiners (NBME) for the proposed cost of $1000 for the Clinical Skills Assessment Exam (CSAE) and the number and location of the testing sites; (2) take all steps necessary to delay implementation of the CSAE as the NBME has not developed an implementation plan that involves reasonable geographic and financial structures; and (3) express deep concern to the NBME that the proposed CSAE imposes unacceptable costs and travel burdens on examinees. (Res. 311, I-01)

D-275.991 License Reciprocity Between States

Our AMA will work jointly with the Federation of State Medical Boards, through its Committee on Portability, to examine license reciprocity between states in order to improve the ability of physicians to practice in other states. (Res. 307, I-01; Reaffirmation A-05)

D-275.992 Unified Medical License Application

Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all medical licensure applications. (Res. 308, I-01)

D-275.993 Reporting of Resident Physicians

Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit, consistent with existing AMA Policy H-265.934 (#4); (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups-- for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4, I-01)

D-275.994 Facilitating Credentialing for State Licensure

Our AMA will: (1) encourage the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) work with the Federation of State Medical Boards and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; and (3) encourage the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license. (Res. 302, A-01)

D-275.995 Licensure and Credentialing Issues

Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions;

(2) work jointly with the FSMB to take measures to encourage increased standardization of credentials requirements, and improved portability by increased use of reciprocal relationships among all licensing jurisdictions;

(3) communicate, either directly by letter or through its publications, to all hospitals and licensure boards that the Joint Commission on Accreditation of Healthcare Organizations encourages recognition of both the Educational Commission for Foreign Medical Graduates' Certification Verification Service and the AMA's Masterfile as primary source verification of medical school credential; and

(4) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. (Res. 303, I-00; Reaffirmation A-04)

D-275.996 Creation of AMA Data Bank on Interstate Practice of Medicine

Our AMA will: (1) continue to study interstate practice of medicine issues as they relate to the quality of care available to patients; (2) explore the provision of information on physician licensure, including telemedicine, to members and others through the World Wide Web and other media; and (3) continue to make information on state legal parameters on the practice of medicine, including telemedicine, available for members and others. (BOT Rep. 6, I-99)

D-275.997 Clinical Skills Assessment (CSA)

Our AMA: (1) will encourage the Educational Commission for Foreign Medical Graduates (ECFMG) to develop additional test sites for CSAs with a re-evaluation of the cost of this examination to minimize the financial and logistical barriers imposed on the applicants;
(2) will support continued development and implementation of a clinical skills examination component into the United States Medical Licensure Examination (USMLE);
(3) will requests the National Board of Medical Examiners (NBME) to provide updates as to the review and validation of their CSA; and
(4) through its representation on the NBME will ask that the CSA not be implemented until the fiscal and geographic burdens are minimized. (CME Rep. 5, A-99)

D-275.999 Board Certification and Discrimination

Our AMA will collect information from members discriminated against solely because of lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification (Res. 314, I-98; Reaffirmed: CME Report 2, A-08)

D-280.000 Long-Term Care

D-280.990 Private Sector Options for Financing Long-Term Care

Our AMA will:

(1) encourage the American public to become better informed about the possible future need for long-term care services, including the importance of early preparation through saving, investing, and the option to purchase long-term care insurance;

(2) support legislative proposals that provide targeted tax incentives that encourage individuals and families to save, invest and insure for their future long-term care needs;

(3) encourage the insurance industry to continue to develop innovative programs and insurance products to cover the provision of long-term care services;

(4) encourage the American public to consider using health savings accounts as a supplemental savings mechanism to cover the future provision of long-term care services;

(5) support legislation that encourages partnerships between public and private entities for the purpose of providing long-term care insurance products;

(6) encourage states to support consumer-directed care programs within Medicaid, such as the Cash and Counseling demonstration project;

(7) support legislation that provides tax subsidies to family caregivers of long-term care; and

(8) support federal demonstration projects that would allow nursing home residents to be moved to home- and community-based care programs with the approval of the patient or patient surrogate, attending physician and under protocols approved by the facility medical director. (CMS Rep. 5, I-04; Reaffirmed and Appended: CMS Rep. 6, I-05)

D-280.991 Medicare Billing for Services Provided by SNF Residents in a Physician's Office

Our AMA will study the problems associated with a change in the Medicare skilled nursing facility (SNF) consolidated billing policy to allow physicians to bill the Medicare program directly for the technical component of services provided to SNF residents in a physician's office. (Res. 112, A-03)

D-280.992 Hospital Discharge Summaries/Medical Transfer Forms

Our AMA, in conjunction with other interested organizations, shall develop a procedure to promote efficient data transfer to accompany discharged patients to acute, long term care and subacute care settings and treating physicians. (Res. 802, A-02)

D-280.993 Evidence-Based Performance Measures and Use of Seclusion and Restraints

(1) The issue of performance measures on the use of seclusion and restraints be referred to the Physician Consortium for Performance Improvement for its consideration. (2) Our AMA will continue vigorously its ongoing efforts to rescind the July 22, 1999, Interim Final Rule of the Centers for Medicare and Medicaid Services (CMS) governing the use of seclusion and restraints requiring face-to-face examination by a physician of a patient in a hospital, nursing home, or residential facility and encourage the ongoing development of performance based measures. (3) A report on the Consortium's deliberations be submitted to the House of Delegates at the 2002 Annual Meeting. (BOT Rep. 16, I-01)

D-280.994 Support of Long-Term Care

Our AMA will strongly encourage the Centers for Medicare & Medicaid Services (CMS) to adopt a quality non-punitive oriented nursing facility survey system, one that is focused on improving medical care. (Sub. Res. 810, I-00)

D-280.995 CMS Seclusion and Restraint Rule

(1) Our AMA will prepare and support enactment of Congressional legislation which would rescind the July 22, 1999, Interim Final Rule of the Centers for Medicare & Medicaid Services governing the use of seclusion and restraints, and direct CMS to engage in a negotiated rule-making process to develop rules which are consistent with AMA Policy 280.952 which states:

Our AMA uses the following principles in establishing policy regarding restraints and seclusion: (a) the patient has the right to be free of restraints and seclusion unless medically necessary. (b) the least restrictive means be considered first. (c) the use of restraints and seclusion is a medical decision and should not be dictated by government agencies. (d) when a physician is not physically present, a properly trained and authorized health care professional may institute seclusion and restraints when this is clinically appropriate. In such cases the physician shall be contacted immediately. The patient must be examined by a physician within a period of time that meets an acceptable clinical standard; and

(2) Our AMA, through its representation on the Joint Commission on Accreditation of Healthcare Organizations, will encourage organizations to utilize evidence-based standards for patient safety which permit physicians to exercise reasonable clinical judgment in the ordering of restraints when such restraints are required for the protection and safety of the patient, other patients, staff, and visitors. (Sub. Res. 802, I-00)

D-280.996 Use of Restraints in Nursing Homes

Our AMA will: (1) continue to work with national medical specialty societies, state medical associations, and other interested groups in advocating for the safety of our patients; and (2) develop evidence-based standards for patient safety with regard to restraints and seclusion. (Sub. Res. 818, A-00)

D-280.997 CMS Interim Final Rule on the Use of Seclusion and Restraints

Our AMA formally opposes CMS's Interim Final Rule "Patients' Rights Conditions of Participation." (Sub. Res. 101, I-99)

D-285.000 Managed Care

D-285.968 Health Insurance Code of Conduct

Our AMA will:
1. develop a Health Insurer "Code of Conduct" setting forth clear and concise principles addressing both medical care policies and payment issues;
2. seek concurrence among health insurers in complying with this "Code of Conduct;"

3. develop a mechanism to monitor compliance with this "Code of Conduct;" and
4. widely disseminate information regarding this "Code of Conduct," and health insurer compliance, to physicians and consumers. (Res. 823, I-08)

D-285.969 Inaccurate Health Plan Physician Directories

Our AMA will solicit and compile member complaints regarding inaccuracies contained in health plan's physician provider listings, and data collected from physician complaints about inaccuracies contained in health plan's provider lists will be aggregated by plan and made available to the membership upon request. (Res. 726, A-07)

D-285.970 Arbitrary and Abusive Economic Profiling

Our AMA will explore the feasibility of participating in legal action designed to address arbitrary and abusive economic profiling of physicians. (Res. 811, I-06)

D-285.971 Rental (Silent) Network PPOs

Our AMA will:
(1) study the issue of rental (silent) network PPO "repricers," and report back to the House of Delegates at the 2007 Interim Meeting;
(2) educate physicians regarding the onerous practice of network "repricing" or silent rental networks; and
(3) distribute our model state legislation for state regulation of the secondary discount market or rental (silent) networks. (Sub. Res. 804, I-06)

D-285.972 Tiered, Narrow, or Restricted Physician Networks

Our AMA will:
(1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network;
(2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting network(s); and
(3) seek legislation or regulation which prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria. (Res. 806, I-06; Reaffirmed in lieu of Res. 729, A-08)

D-285.973 Clinical Integration

Our AMA will work with state medical societies to develop a white paper to educate physicians regarding clinical integration, including: (a) defining clinical integration; (b) researching Federal Trade Commission and Department of Justice advisories on clinical integration; (c) monitoring the progress of clinically integrated groups; (d) making policy and legislative recommendations; (e) developing a program to educate physicians about the benefits to physicians and patients, as well as the threats, concerning creating clinically integrated physician practices. (Res. 714, A-06)

D-285.974 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations

Our AMA will continue to receive information on and monitor the issue of restrictions on referrals in all health care delivery settings. (BOT Rep. 38, A-06)

D-285.975 Physicians' Ability to Provide Access to Medical Care for Economically Disadvantaged Americans

Our AMA will: (1) upon request, review and provide feedback on surveys designed by the National Medical Association (NMA) and other parts of the Federation to assess physician denial and deselection;

(2) develop a report based on Socioeconomic Monitoring System data on physician participation, denial, and deselection with respect to managed care plans, including how those measures vary by physician race, and that it be widely circulated throughout the Federation; and

(3) if data suggest that any specific managed care organization (MCO) has discriminated against minority physicians, join with the NMA and relevant state or county medical societies in developing appropriate legal and advocacy strategies, such as drafting a letter to the appropriate state or federal office or to that MCO. (BOT Action in response to referred for decision Res. 110, I-01)

D-285.976 Management of Chronic Disease

Our AMA will educate physicians on the impact of disease management programs on patients and their treating physicians. (CSA Rep. 11, A-04)

D-285.977 Excessive Telephone Wait Times for Physician Appeals of Managed Care Decisions on Patient Care

Our AMA will specifically encourage Congress to write legislation mandating that managed care organizations be required to staff physician contact phone numbers concerning appeals for denied care sufficiently to maintain no more than a five minute average wait time. (Res. 223, A-04)

D-285.978 Limiting Financial Incentives to Withhold Appropriate Care

Our AMA will: (1) advise state medical associations that Section 10 of Chapter 141 on managed care practices in the insurance industry of the Massachusetts Acts of 2000 is consistent with AMA policy, and is an appropriate model for state legislation on risk arrangements and financial incentives; and (2) urge physicians to make use of existing resources, particularly the AMA Model Managed Care Contract, to ensure that they are not unduly pressured by financial incentives to withhold appropriate care. (CMS Rep. 4, I-03)

D-285.979 Disease Management

Our AMA will: (1) reevaluate the concept of disease management as a way to provide more cost effective delivery and improved quality of medical care to patients with chronic disease involving cooperation between physicians and teams of allied health care workers, including pharmacists, registered nurses, benefit managers, home health care, etc., and report back to the House of Delegates at the 2003 Interim Meeting; and (2) educate physicians about the benefits of properly designed and implemented disease management programs that are consistent with AMA policy. (Res. 114, A-03)

D-285.980 Medical Care "Carve-Outs"

Our AMA shall develop model state legislation consistent with Policy H-285.923, and encourage states to enact such legislation. (CMS Rep. 7, A-02)

D-285.981 Continuity of Physicians and Pharmaceuticals

Our AMA shall: (1) draft federal legislation on patient access to needed health care be modified to reflect AMA policies related to continuity of care, including patient access to medically necessary pharmaceuticals; (2) continue to advocate AMA policies related to continuity of care, including patient access to medically necessary pharmaceuticals, in its ongoing discussions with health plans; and (3) continue to strongly advocate for the enactment of federal legislation consistent with AMA policies related to continuity of care, including patient access to medically necessary pharmaceuticals. (CMS Rep. 8, A-02)

D-285.982 Criteria for Level of Care Status

Our AMA will: (1) urge the American Hospital Association to encourage hospitals to work with the medical staff toward the use of a uniform standard for level of care status in all their payer contracts; and (2) work with the Centers for Medicare and Medicaid Services to eliminate the use of "inpatient only" criteria, which is currently a part of the Ambulatory Payment Classification (APC) implementation of the Out-Patient Prospective Payment System (OPPS). (CMS Rep. 5, I-01)

D-285.983 Managed Behavioral Health Organizations (MBHOs)

Our AMA will inform Managed Behavioral Health Organizations (MBHOs) of this policy and work with MBHOs to implement means for improving coordination of care with primary care physicians. (Res. 702, I-01)

D-285.984 Medicare Review Activities

Our AMA will continue its strong support and advocacy efforts towards passage of a regulatory relief bill for physicians that includes written advice from Medicare contractors, limits on extrapolation, and stronger due process rights. (CMS Rep. 7, I-01)

D-285.985 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will urge physicians who are experiencing problems with health plans to complete the Health Plan Complaint Form available on the AMA Private Sector Advocacy Web site at http://www.ama-assn.org/ama/pub/category/2387.html. (CMS Rep. 6, I-01; Reaffirmation A-06)

D-285.986 Anti-"Carve-Out"

Our AMA will further study the issue of carve-outs and develop a clear definition of the term. (Sub. Res. 709, A-01)

D-285.987 Mental Health "Carve-Outs"

Our AMA will: (1) encourage third party payers using mental health carve-out programs to contract with managed behavioral health care organizations that have met the standards of recognized private sector accrediting bodies;

(2) encourage private sector accrediting bodies collecting quality assessment data of managed behavioral healthcare organizations to widely disseminate such information to the public;

(3) urge managed behavioral health care organizations to provide health plan enrollees with clear and easily understandable information on how to access the organization's mental health services;

(4) urge managed behavioral health care organizations that implement mental health carve-out programs to remove any barriers from their "intake" procedures that interfere with timely communication and collaboration between attending physicians and psychiatrists; and

(5) work closely with relevant specialty groups to develop AMA strategies for corrective actions to eliminate discriminatory mental health policies in health plans and report back to House of Delegates as soon as possible. (CMS Rep. 6, I-00)

D-285.988 Managed Care Contract Deadline

Our AMA will draft model state legislation and amend the AMA's Model Managed Care Contract to reflect AMA policy regarding the marketing of physicians as network participants. (Sub. Res. 703, I-00)

D-285.989 Time-Based Administrative Charges

Our AMA will: (1) ask the CPT Editorial Panel to consider development of a time-based CPT code for complex administrative time expended on behalf of our patients; and (2) develop model legislation to require third party payers to compensate physicians for these activities. (Res. 806, I-99)

D-285.990 Denied and Down-Coded Days

Our AMA's Office of General Counsel will immediately and actively pursue relief under the Federal RICO statutes or other federal or state statutes, as may be appropriate, to address the intimidation used by managed care organizations against physicians, hospitals, and patients. (Res. 716, I-99)

D-285.991 Health Plan and Fiscal Intermediary Insolvency Protection Measures

Our AMA will: (1) seek to have input into the National Association of Insurance Commissioners deliberations regarding insolvency protection measures, for consumers, physicians, hospitals and other providers with regard to managed care organizations and other entities that accept financial risk for delivering health care services; and (2) immediately develop model state legislation and/or modify existing model state legislation requiring the reimbursement of physicians for health care services rendered prior to the declaration of insolvency of health plans or fiscal intermediaries from the assets of the insurer or plan or from the state guaranty fund. (Res. 717, I-99)

D-285.992 Class Action Lawsuit

Our AMA will study the feasibility of a class action lawsuit against third party payers and managed care plans concerning non-negotiable contracts imposed upon physicians which violate the laws of discrimination and equal protection. (Sub. Res. 708, I-99)

D-285.993 Pharmacy Benefit Risk-Sharing by Physicians

Our AMA will: (1) modify its "Model Managed Care Services Agreement" to include a provision that prohibits the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third party payers; and (2) develop model state legislation that prohibits the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third party payers. (CMS Rep. 12, I-99)

D-285.994 Creation of Model State and Local Medical Society Private Sector Advocacy Programs

(1) Our AMA will develop as part of the Private Sector Advocacy Program, a model that could be used by state and local medical societies to deal with physician and patient issues with health plans. (2) The development and implementation of this program be a high priority item. (Res. 719, I-99; Reaffirmation A-05)

D-285.995 Coordination of Information on Third Party Relations Activities

Our AMA will utilize its website and other appropriate resources to coordinate the distribution and exchange of information associated with third party relations programs at the local and state level. (Res. 704, I-99)

D-285.996 Coercive Contracting

Our AMA will: (1) study the prevalence of hospitals requiring hospital-based physicians to accept all managed care contracts negotiated by the hospital without physician input; and (2) pursue meetings with interested specialty socieites to address a list of strategies to address coercive contracting in the current marketplace and an action plan to implement them. (Res. 725, A-99; Amended: BOT Action in response to referred for decision Resolve 2 of Res. 725, A-99)

D-285.998 Creation of Joint AMA Committee with Representatives from the American Association of Health Plans

Our AMA will continue to work with the American Association of Health Plans and other appropriate organizations on issues of mutual interest. (Sub. Res. 704, I-98; Modified: CLRPD Rep.1, A-03)

D-285.999 Mandatory Use of Hospitalists

Our AMA will continue its advocacy of Policy H-285.932, in both its private sector and Joint Commission activities by opposing the mandatory use of hospitalists and providing resources and support to physicians facing implementation of mandatory hospitalist policies. (Sub. Res. 714, I-98; Reaffirmed: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05)

D-290.000 Medicaid and State Children's Health Insurance Programs
(See also: Health Care Reform; Medicare)

D-290.982 State Children’s Health Insurance Program Reauthorization (SCHIP)

1. Our AMA strongly supports the State Children's Health Insurance Program reauthorization and will lobby toward this end.

2. Our AMA will lobby Congress to:
a. provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through SCHIP through an enhanced federal match;
b. allow states to use SCHIP funds to augment employer-based coverage;
c. allow states to explicitly use SCHIP funding to cover eligible pregnant women;
d. allow states the flexibility to cover all eligible children residing in the United States and pregnant women through the SCHIP program without a mandatory waiting period;
e. provide $60 billion in additional funding for SCHIP to ensure adequate funding of the SCHIP program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate; and
f. ensure predictable funding of SCHIP in the future.

3. Our AMA will urge Congress to provide targeted funding for SCHIP enrollment outreach. (Res. 117, A-07; Res. 118, A-07; Res. 119, A-07)

D-290.983 Children's Rights to Receive Health Care Services Under the Medicaid Act

Our AMA will take all reasonable steps to introduce and pass legislation which would: (1) confirm, clarify and codify Congressional intent that Medicaid-eligible children have an enforceable right to receive Early Periodic Screening, Diagnosis, and Treatment services and a right to enforce the equal access provision; and (2) overturn the reasoning applied by the United States Court of Appeals for the Tenth Circuit in *Oklahoma Chapter of the American Academy of Pediatrics v. Fogarty*. (Res. 114, A-07)

D-290.984 State Plan Amendments for Medicaid and Medicaid Task Force

Our AMA will: (1) promote mechanisms that provide the opportunity for public comment and legislative oversight prior to submission of the State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services, including the development of model state legislation, as appropriate; and (2) serve as a repository of information relating to the outcomes of SPAs in different states,

disseminate such information and educate physicians about the impact of proposed changes to Medicaid via SPAs. (Sub. Res. 701, I-06)

D-290.985 Protecting Children, Adolescents and Young Adults in Medicaid and the State Children's Health Insurance (SCHIP) Program

Our AMA will actively: (1) encourage state and county medical societies to advocate for initiatives to ensure that all eligible children, adolescents, and young adults are enrolled in Medicaid and SCHIP; (2) advocate for federal and state funding for Medicaid and SCHIP so that funding is sufficient to support enrollment of and provision of necessary services to all eligible children, adolescents, and young adults; and (3) encourage state and county medical societies to work to ensure that services to children, adolescents, and young adults meet Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Standards. (Res. 108, A-06)

D-290.986 Capitation of Medicaid Funding for Guam and Other US Territorial Possessions

The AMA will support:

(1) Repeal of 42 USC §1308(f) and to allow Guam and other Territorial Possessions and Island Nations to participate in the Medicaid program on the same terms as the States, without capitation of matching funds;

(2) Amending 42 USC §1396(d)(b)(2) by striking "50 per centum" and by inserting in lieu thereof: "determined in the same manner as such percentage is determined for the States under this subsection"; this will allow the Territories to participate in the Medicaid program on the same terms as the States; and

(3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD. (BOT Action in response to referred for decision Res. 215, I-00)

D-290.987 Early and Periodic Screening, Diagnosis, and Treatment

Our AMA (1) reaffirms the importance of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; (2) will advocate for EPSDT to remain intact as critical to the health and well-being of children; and (3) will instruct the Medicaid Advisory Commission of the desirability of this action. (Res. 708, I-05)

D-290.988 Medicaid Funding Cuts

Our AMA will vigorously oppose components of the House version of budget reconciliation which would impose mandated premiums and copayments for acute care services and pharmaceuticals on children at 133% of the federal poverty level or below. (Res. 724, I-05)

D-290.989 Diagnosis and Treatment of Hearing and Balance Disorders

Our AMA will actively oppose the Centers for Medicare and Medicaid Services' proposed regulation CMS-2132-P, "Medicaid Provider Qualifications for Audiologists," as soon as possible. (Res. 128, A-03)

D-290.990 Payment of Federally-Mandated Crossover Payments for Dually Eligible People who have Joined Medicare HMOs

Our AMA will alert physicians throughout the nation that the Balanced Budget Act of 1997 mandated that states continue to pay crossover payments for dually eligible people who have joined a Medicare HMO. (Res. 109, A-03)

D-290.991 Medical Care for Patients with Low Incomes

(1) The testimony and comments in reference committee and House of Delegates discussions regarding the model outlined under the heading "Medical Care for Patients with Low Incomes" in this report will be forwarded to the Council on Medical Service for consideration in developing its recommendations; and (2) Members of the House of Delegates, state medical associations, and national medical specialty societies will be encouraged to forward any additional comments on the model outlined under the heading "Medical Care for Patients with Low Incomes" in this report to the Council on Medical Service by August 1, 2003. (CMS Rep. 8, A-03)

D-290.992 Establishment of National Medicaid Database

The AMA support development of draft model state legislation that would establish that each state collect outpatient encounter data into a standardized state database to be used for the monitoring of Medicaid payment policies and utilization of services. (BOT Rep. 13, I-02)

D-290.993 Nationalized Medicaid Study

Our American Medical Association shall study the benefits and risks of a nationalized Medicaid program, and report back to the AMA House of Delegates by the 2003 Interim Meeting. (Res. 722, I-02)

D-290.994 State-Provided Coverage Of Medical Formula for Uninsured People Suffering From Phenylketonuria (PKU) Regardless of Age or Gender

Our AMA shall encourage individual state medical societies to support legislation within their jurisdictions that would provide Medicaid funding and coverage of medical formula and foods for Medicaid patients, regardless of age or gender, suffering from phenylketonuria (PKU). (Res. 415, A-02)

D-290.995 The Effects of Closing Safety Net Hospitals

Our AMA will support federal legislation that would extend Medicaid Disproportionate Share Hospital (DSH) payments into 2003 and beyond, thereby contributing to the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients. (CMS Rep 3, I-01)

D-290.996 Health Insurance Flexibility and Accountability (HIFA) Demonstration Waivers

Our AMA will: (1) request that the Centers for Medicare and Medicaid Services undertake a comprehensive evaluation of the impact of the Health Insurance Flexibility and Accountability (HIFA) demonstration project on children and pregnant women; and

(2) work closely with the AAP in ensuring that the Department of Health and Human Services implements the findings of the 2001 General Accounting Office (GAO) report titled "Medicaid and SCHIP: States' Enrollment and Payment Policies can Affect Children's Access to Care" specifically:
(a) simplifying the application and enrollment process;
(b) utilizing presumptive eligibility;
(c) encouraging states to refrain from increases in their cost-sharing requirements; and
(d) setting Medicaid and SCHIP payment rates at a level that encourages wide health care physician participation in both programs.
(Res. 116, I-01)

D-290.997 Cost-Effectiveness of Medicaid Eligibility Criteria for the Chronically Ill

Our AMA will examine the appropriateness and cost-effectiveness of "the spend down option" to meet Medicaid eligibility criteria in the broader context of Medicaid reform with a report back at the 2002 Interim Meeting. (Res. 102, I-01)

D-290.998 Medicare/Medicaid Dual Eligibles

Our AMA will pursue all appropriate measures including, but not limited to, the development and passage by Congress of legislation to require the federal government to directly provide or mandate that states provide full reimbursement for Medicare deductibles and co-payments for all patients who are Medicare/Medicaid dual eligible. (Res. 102, A-01)

D-290.999 Status Report On Expanding Coverage For The Uninsured

Our AMA will commend the Medical Student Section on its 2000-2002 community service project to encourage outreach and enrollment in the State Children’s Health Insurance Program. (CMS Rep. 6, A-01)

D-295.000 Medical Education

D-295.931 Update on the Availability of Clinical Training Sites for Medical Student Education

1. Our AMA will work with organizations such as the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to study and report the current and projected availability of and need for clinical clerkship placements for US medical students.

2. Our AMA will work with appropriate collaborators to study how to build additional institutional and faculty capacity in the US for delivering clinical education.

3. Our AMA, in collaboration with interested stakeholders, will:
(a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from

medical schools that are approved by an independent public or private organization, such as the Liaison Committee on Medical Education, using principles consistent with those used to accredit US medical schools;
(b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety; and
(c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for Liaison Committee on Medical Education and American Osteopathic Association accredited programs.

4. Our AMA will study whether the "public service community benefit" commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.

5. Our AMA opposes any arrangements of US medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially. (CME Rep. 2, I-08)

D-295.932 Medical Education in Disaster Response

Our AMA will study the current status of disaster preparedness education and training in medical schools, with report back to the House of Delegates at the 2009 Annual Meeting, and in graduate and continuing medical education programs with a report back to the House of Delegates at the 2010 Annual Meeting. (Res. 319, A-08)

D-295.933 Transparency In Medical Schools' Utilization of Funds From Tuition and Fee Increases

Our AMA encourages the development of policies by Liaison Committee on Medical Education- and American Osteopathic Association-accredited medical schools that ensure information on the use of funds from tuition and fee increases is disclosed in a standardized format and in a timely manner to prospective and current medical students. (Sub. Res. 310, A-08)

D-295.934 Encouragement of Interprofessional Education Among Health Care Professions Students

Our AMA: (1) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (2) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools. (Res. 308, A-08)

D-295.935 One-Year Public Health Training Options for All Specialties

Our AMA will: (1) offer its participation in the future planning to implement the recommendations in the Institute of Medicine report, *Training Physicians for Public Health Careers*; and (2) in the context of its Initiative to Transform Medical Education (ITME), study opportunities for integrating content related to public health and preventive medicine across the medical education continuum and report back at the 2009 Annual Meeting. (CME Rep. 8, A-08)

D-295.936 Educational Implications of the Medical Home Model

Our AMA:

(1) encourages the integration of medical education into Patient-Centered Medical Home (PC-MH) demonstration projects;

(2) will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to review their accreditation standards so as not to impede education in and about the PC-MH model;

(3) will advocate for funding from all sources for medical schools and residency training programs to provide medical education in the context of PC-MH models; and

(4) will monitor the evolution of the concept of the medical home and track the implementation by teaching programs, with a report back at the 2010 Annual Meeting. (CME Rep. 4, A-08)

D-295.937 Competition for Clinical Training Sites

Our AMA will, through the Council of Medical Education, conduct an analysis of the adequacy of clinical training sites to accommodate the increasing number of medical students in the US accredited medical schools and study the impact of growing pressure, including political and financial, to accommodate clinical training in US hospitals for US citizen international medical students. (Res. 324, A-08)

D-295.938 Increasing Medical School Class Sizes

Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (Res. 309, A-08)

D-295.939 Independent Regulation of Physician Licensing Exams

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, "Voting Rights for AMA-MSS NBME Representatives;" (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08)

D-295.940 Physician Lifelong Learning

Our AMA will, through its Initiative to Transform Medical Education, study the following and report back at the 2009 Annual Meeting: (a) the status of teaching the "basic science" of lifelong learning during medical school and residency training, including evidence-based medicine, information retrieval, and critical analysis of the literature, (b) the strategies that have been effective in teaching the skills of self-assessment among physicians-in-training and in practice, and in promoting their use, (c) the patterns of utilization of the various continuing medical education (lifelong learning) modalities by physicians, with the identification of those that are both efficient and effective for planning, tracking, and documenting learning experiences, as well as changing practice behavior, and (d) the mechanisms that are effective in mitigating the actual and opportunity costs of participating in lifelong learning.

Our AMA will, based on this study, work with other relevant bodies to develop and monitor the implementation of recommendations directed at the medical education community, including accrediting, certifying, and licensing bodies, as well as educational institutions and programs, aimed at assuring that physicians are prepared to engage in lifelong learning and report the results at the 2010 Annual Meeting. (CME Rep. 3, A-08)

D-295.941 Facilitating Access to Health Care Facilities for Training

Our AMA will continue to work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings. (Res. 811, I-07)

D-295.942 Patient Safety Curricula in Undergraduate Medical Education

Our AMA will explore the feasibility of asking the Liaison Committee on Medical Education to encourage the discussion of basic patient safety and quality improvement issues in medical school curricula. (Res. 801, I-07)

D-295.943 Uses of Simulation in Medical Education – to Simulate or not to Simulate?

1. Our AMA will: (a) through its Council on Medical Education, monitor the developments in uses of simulation and simulators in physician preparation for entry and re-entry into clinical practice, and provide an update to the AMA House of Delegates at the 2009 Annual Meeting; and (b) disseminate the information in this report.

2. Our AMA will advocate for additional funding for research to further assess the effectiveness of simulation and to implement the use of simulators for use in both teaching and assessment.

3. Our AMA will work with appropriate organizations and institutions to convene a meeting on the use of simulation in medical education. (CME Rep. 15, A-07)

D-295.944 Current and Future Availability of Resources to Support the Clinical Education of Medical Students

1. Our AMA, in collaboration with the Association of American Medical Colleges; the American Osteopathic Association; the American Association of Colleges of Osteopathic Medicine; and other relevant stakeholder groups, such as the Educational Commission for Foreign Medical Graduates will: (a) collect data on the strategies being used by existing and developing medical schools to meet their current and anticipated resource needs for clinical education; (b) identify the current and anticipated gaps in resources for clinical education; and (c) develop a strategic plan to address the identified gaps, including (i) creating an advocacy

agenda and (ii) identifying model programs and best practices and disseminating the results.

2. Our AMA will continue to monitor the expansion medical schools and the increase in the number of medical students taking their clinical education in the US.

3. Our AMA will report to the House of Delegates at the 2008 Interim Meeting the results of its data gathering related to medical education expansion and its advocacy activities in support of adequate resources for medical student clinical education. (CME Rep. 14, A-07)

D-295.945 Initiative to Transform Medical Education: Strategies for Medical Education Reform

1. Our AMA will work to gain consensus for the agenda for transforming medical education with appropriate coordinated stakeholder collaboration and action.

2. Our AMA will work with collaborators to select priority areas for change in medical education, collect data on best practices in these areas, and develop plans for model programs that address identified gaps in physician preparation and continuing professional development and training.

3. Existing AMA policies and directives for action will be reviewed and, if necessary, new policies and directives will be created to facilitate the implementation of needed changes in medical education.

4. A report on progress in implementation and evaluation of identified changes in medical education will be prepared for the 2008 Annual Meeting of the House of Delegates. (CME Rep. 13, A-07)

D-295.946 The Status of Education in Substance Use Disorders in America's Medical Schools and Residency Programs

Our AMA will:
(1) advocate for in-depth qualitative studies to facilitate the preparation of physicians to care for patients with substance use disorders;
(2) facilitate the identification, dissemination, and implementation of successful substance use disorder educational programs across the educational continuum;
(3) encourage the Accreditation Council for Graduate Medical Education (ACGME) to include education about substance use disorders in their program accreditation requirements;
(4) encourage the American Board of Medical Specialties (ABMS) to encourage its member boards to include substance use disorder questions in their certification process; and
(5) through its Council on Medical Education, monitor and track implementation of the recommendations of the December 2006 House Office of National Drug Control Policy White House Leadership Conference on Medical Education in Substance Abuse report. (CME Rep. 11, A-07)

D-295.947 A Balanced Medical Curriculum

1. Our AMA, through its Initiative to Transform Medical Education and in collaboration with relevant groups, will study ways to apportion relevant content related to the six Accreditation Council for Graduate Medical Education core competencies across the medical education continuum.

2. Our AMA will (a) collaborate with other groups to define changes to the clinical education environment that would support medical student and resident physician acquisition of appropriate core competencies, and (b) continue to advocate for appropriate funding for education to support these changes.

3. A report will be prepared for the 2009 Annual Meeting of the House of Delegates summarizing actions taken and successes achieved in bringing about educational program and clinical learning environment change. (CME Rep. 9, A-07)

D-295.948 Report on the Status of Education in Substance Abuse and Addiction in America's Medical Schools and Residency Programs

Our AMA Council on Medical Education will produce a report of the status of education in substance use and addiction in America's medical schools and residency programs. (Res. 314, A-06)

D-295.949 Criminal Background Checks for Medical Students

Our AMA will:

(1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for

criminal background checks for applicants accepted to medical school and enrolled medical students, including the creation of guidelines for appropriate action related to individuals whose background checks raise concerns;

(2) work to ensure that systems for criminal background checks for accepted applicants and medical students are standardized within and across institutions, as well as equitable, cost-effective, and consistent with the requirements for background checks being required of resident physicians and practicing physicians; and

(3) continue to monitor the requirement for criminal background checks for accepted applicants and medical students by medical schools, hospitals/health systems, and state laws. (CME Rep. 9, A-06)

D-295.950 Equal Fees for Osteopathic and Allopathic Medical Students

Our AMA will: (1) collect data to address the following questions: (a) whether allopathic medical students have access to electives at DO-granting schools and, if so, whether the fees charged are the same as or higher than the fees charged to students from other osteopathic medical schools; and (b) whether osteopathic medical students are charged the same or higher fees for electives taken at allopathic medical school than the fees charged to students from other allopathic medical schools; and (2) prepare a report based on the information collected for the 2007 Annual Meeting of the House of Delegates, with a final recommendation related to Resolution 809 (I-05). (CME Rep. 14, A-06)

D-295.951 Medical Student Clinical Education and Training Conditions: A Follow-up Report on LCME Actions

1. Our AMA encourages the Liaison Committee on Medical Education to continue to monitor compliance with its standard on medical student hours, through its annual survey of medical schools and through its accreditation reviews. If noncompliance with the requirement for medical schools to have policies and practices related to student work load is identified during the annual survey or the accreditation review, the LCME should take timely action to bring schools into compliance.

2. Our AMA will request the Association of American Medical Colleges to add an item to the AAMC Medical School Graduation Questionnaire that asks whether student duty hours were monitored. (CME Rep. 5, A-06)

D-295.952 Update on the American Medical Association Initiative to Transform Medical Education

Our AMA will, through its Initiative to Transform Medical Education, continue to work collaboratively with other organizations to bring about mutually agreed-upon reforms across the continuum of medical education aimed at enhancing physician and health system performance to better meet the health care needs of the public. (CME Rep. 3, A-06)

D-295.953 Medical School Accreditation

Our AMA will:

(1) disseminate an informational packet to state medical societies for use in communicating the meaning and importance of accreditation to various constituencies;

(2) prepare and disseminate an analysis of the legal options to promote the accreditation of branch campuses of non-US medical schools, including the development of model state legislation;

(3) provide this information to delegates and alternate delegates; and

(4) explore partnering with the Association of American Medical Colleges, which has the standardized application, to ensure that everyone making an application gets the informational packet on the importance of accreditation through those means. (BOT Action in response to referred for decision Res. 318, A-99)

D-295.954 Teaching and Evaluating Professionalism in Medical Schools

Our AMA will:

(1) strongly urge the Liaison Committee on Medical Education (LCME) to promptly create and enforce uniform accreditation standards that require all LCME-accredited medical schools to evaluate professional behavior regularly as part of medical education;

(2) strongly urge the LCME to develop standards for professional behavior with outcome assessments at least every eight years, examining teaching and evaluation of the competencies at LCME-accredited medical schools;

(3) recognize that evaluation of professionalism is best performed by medical schools and should not be used in evaluation for

licensure of graduates of LCME accredited medical schools;

(4) continue its efforts to teach and evaluate professionalism during medical education; and

(5) actively oppose, by all available means, any attempt by the National Board of Medical Examiners and/or the Federation of State Medical Boards to add separate, fee-based examinations of behaviors of professionalism to the United States Medical Licensing Examinations. (Res. 304, A-05)

D-295.955 Educating Medical Students about the Pharmaceutical Industry

Our AMA will strongly encourage medical schools to include: (1) unbiased curricula concerning the impact of direct-to-consumer marketing practices employed by the pharmaceutical industry as they relate to the physician-patient relationship; and (2) unbiased information in their curricula concerning the pharmaceutical industry regarding (a) the cost of research and development for new medications, (b) the cost of promoting and advertising new medications, (c) the proportion of (a) and (b) in comparison to their overall expenditures, and (d) the basic principles in the decision making process involved in prescribing medications, specifically using evidence based medicine to compare outcomes and cost effectiveness of generic versus proprietary medications of the same class. (Res. 303, A-05)

D-295.956 Medical Student Clinical Training and Education Conditions

Our AMA will:

(1) commend the LCME for addressing the issue of the medical student learning environment including student hours assigned during the clinical years;

(2) strongly encourage the LCME to continue to monitor work hour policies for medical students, to evaluate student work hours and educational environment in the clinical setting during regular accreditation reviews and to determine any impact on medical students resulting from the enforcement of duty-hour standards by the ACGME;

(3) request that the LCME modify its standard on medical student hours and its accompanying annotation to state as follows:

ED-38. The committee [responsible for the curriculum] should give careful attention to the impact of the amount of work required, including the frequency of examinations and their scheduling during the preclinical years; and on-call hours during the clinical years.

ANNOTATION: In addition to monitoring the amount of classroom time and examination frequency, attention should be paid to the hours that medical students work during the clinical years and the educational value of their clinical activities. Students' duty hours should be set taking into account the effects of fatigue and sleep deprivation on learning and patient care. Medical student hours should not exceed resident duty hours as delineated by the Accreditation Council for Graduate Medical Education (ACGME); and

(4) monitor the action of the LCME and report back to the House of Delegates when final action has been taken. (CME Rep. 5, I-04)

D-295.957 Medical Student and Resident Physician Education about Pharmaceutical Advertising to Health Professionals

Our AMA will encourage all medical schools and residency programs to educate their students and resident physicians on the possible effects of pharmaceutical advertising and interaction with health professionals and on alternative unbiased sources of information about pharmaceutical products through the AMA curriculum, "What You Should Know About Gifts to Physicians From Industry." (Res. 302, A-04; Reaffirmed: Res. 303, A-05)

D-295.958 Support of Business of Medicine Education for Medical Students

Our AMA will encourage all US medical schools to provide students with a basic foundation in medical business, drawing upon curricular domains referenced in Undergraduate Medical Education for the 21st Century (UME-21), in order to assist students in fulfilling their professional obligation to patients and society in an efficient, ethical, and cost-effective manner. (Res. 305, A-04)

D-295.959 Musculoskeletal Care in Graduate Medical Education

Our AMA will: (1) strongly urge our medical schools to formally reevaluate the musculoskeletal curriculum;

(2) strongly urge our medical schools to make changes that ensure medical school students have the appropriate education and training in musculoskeletal care, and make competence in basic musculoskeletal principles a graduation requirement for medical school; and .

(3) encourage its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical

Education, and the various Residency Review Committees to promote higher standards in basic competence in musculoskeletal care in accreditation standards. (Res. 310, A-03)

D-295.960 Clinical Skills Training in Medical Schools

Our AMA will encourage medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools. (Res. 324, A-03)

D-295.961 Proposed Consolidation of Liaison Committee on Medical Education Offices

Our AMA will continue to support the current dual Secretariat structure for the management of the Liaison Committee on Medical Education. (CME Rpt. 7, A-03)

D-295.962 Prevention of Harassment and Discrimination of Women in Medicine

The AMA Model Harassment and Discrimination Grievance Policy and Procedure will be widely distributed throughout the medical education community and placed on the AMA Web site. (CME Rpt. 3, A-03)

D-295.963 Continued Support for Diversity in Medical Education

Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education. (Res. 325, A-03)

D-295.964 Pharmaceutical Federal Regulations -- Protecting Resident Interests

Our AMA shall continue to evaluate and oppose, as appropriate, federal regulations on the pharmaceutical industry that would curtail educational and/or research opportunities open to residents and fellows that are in compliance with current AMA ethical guidelines. (Res. 921, I-02)

D-295.965 Clinical Skills Assessment As Part Of Medical School Standards

Given the importance of assessing clinical competency, our AMA strongly urge the Liaison Committee on Medical Education and the American Osteopathic Association to modify and enforce uniform accreditation standards as soon as possible to require that all medical schools rigorously and consistently assess clinical skills of all students as a requirement for advancement and graduation. (Sub. Res. 821, I-02)

D-295.966 Pain Management Standards and Performance Measures

Our AMA, through the Council on Medical Education, shall continue to work with relevant medical specialty organizations to improve education in pain management in medical schools, residency programs, and continuing medical education programs. (CSA Rep. 4, A-02)

D-295.967 Improving the Quality of Geriatric Pharmacotherapy

(1) Our AMA shall consider convening a task force of relevant specialty societies and other stakeholders to study ways to improve physicians' understanding of geriatric pharmacology and to educate physicians on the special pharmacological needs of the geriatric population. Physicians must have a readily accessible source of current and complete dose response information to individualize drug therapy and minimize the risks of adverse drug reactions. (2) CSA Rep. 5, A-02 shall be widely distributed to key audiences, including medical schools and residency training programs. (CSA Rep. 5, A-02)

D-295.968 Proposed Implementation of Clinical Skills Assessment Exam

(1) Our AMA shall urgently contact the National Board of Medical Examiners (NBME), all organizations represented on the NBME Governing Board, and the Federation of State Medical Boards to request suspension of the implementation of the proposed Clinical Skills Assessment Examination (CSAE) until such time as: (a) The examination has been demonstrated to be statistically valid, reliable, practical, and evidence-based;(b) Scientific studies have been published in peer review journals validating the examination for US medical students and graduates and demonstrating that the fiscal and societal benefits of the examination justify the costs; and (c) Testing sites are available in more reasonable geographic locations than currently proposed by the NBME.

(2) Our AMA and state medical societies shall encourage state medical licensing boards to exclude the CSAE from state medical licensure requirements until the above conditions are met.

(3) Our AMA shall continue the dialogue with the NBME and the Federation of State Medical Boards concerning the implementation

of the CSAE.

(4) Our AMA shall ask its representatives to the Liaison Committee on Medical Education to ensure that medical students' clinical skills are assessed regularly during their clinical training. (Sub. Res. 308, A-02)

D-295.969 Geriatric and Palliative Care Training For Physicians

Our AMA will encourage geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities. (Res. 305, A-02)

D-295.970 HIV Postexposure Prophylaxis for Medical Students During Electives Abroad

Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. (Res. 303, A-02)

D-295.971 The Effect of the Nursing Shortage on Medical Education

Our AMA shall encourage accrediting bodies for medical education programs (the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education) to rigorously enforce (or develop and enforce) standards to ensure that the educational experience of trainees is not compromised by inadequate staffing levels of nursing and ancillary personnel in teaching hospitals. (CME Rep. 8, A-02)

D-295.972 Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students

Our AMA shall: (1) encourage standardized Advanced Cardiac Life Support (ACLS) training for medical students prior to clinical clerkships; and (2) strongly encourage medical schools to fund ACLS training for medical students. (Res. 314, A-02)

D-295.973 Establishing Appropriate Medical Student Training Conditions

Our AMA shall work with the Liaison Committee on Medical Education to develop standards addressing appropriate medical student training hours and training conditions during clinical clerkships. (Res. 304, A-02)

D-295.974 Loan Repayment Program Database

Our AMA shall work with the Association of American Medical Colleges in the expansion of the AAMC's existing web site to include a comprehensive, searchable database of loan repayment programs run by states, counties, hospitals and similar organizations. (Res. 302, A-02)

D-295.975 Comprehensive Reform at the Interface of Medical Education and Health Care

(1) Our AMA shall develop plans for a comprehensive initiative that will address the interface of medical education and health care, including the following goals:
(a) A medical education program that equips young physicians with the knowledge, skills, attitudes, and values necessary to provide quality medical care, and the ability to continually update their learning as they move through the educational pipeline and into practice;
(b) Appropriate sources and levels of funding to support medical education across the continuum (undergraduate, graduate, and continuing);
(c) A decrease in the debt burden of young physicians;
(d) Appropriate sources and levels of funding to support the missions of teaching institutions in providing care to the underserved and to other populations; and
(e) Appropriate resources (faculty, clinical sites, patients, technology) to ensure the quality of clinical education.

(2) Based on the commitment to the above goals, the AMA Board of Trustees convene an internal working group with representation from relevant Councils and Sections to accomplish the following by early 2003:
(a) Develop a comprehensive set of issues to be addressed in the initiative, and specific priorities for action;
(b) Summarize the current status of each priority area;
(c) Define areas for additional data gathering;
(d) Identify external groups to include in initial discussions of outcome goals; and
(e) Develop and initiate plans for external funding for the initiative.

(3) Our AMA shall begin, during 2003, a broad-based, invitational initiative to accomplish the following: (a) Obtain broad-based consensus on the issues needing priority attention; (b) Develop recommendations to appropriate stakeholder groups, including those that regulate, pay for, and deliver health care and medical education on the priority areas; (c) Develop and disseminate plans to implement the recommendations. (CME Rep. 6, A-02)

D-295.976 Education for Practice in Interprofessional Teams

Our AMA: (1) shall continue to explore whether interprofessional educational experiences, when appropriately structured to recognize different levels of prior education and expertise among learners, can be a useful mechanism to achieve certain desirable educational goals, including understanding of and respect for the roles of the various health professions and understanding of and skills in interprofessional team practice; (2) shall continue to collect data on interprofessional educational experiences involving medical students and resident physicians, and identify and disseminate information on the characteristics of these programs that contribute to successful learner outcomes; and (3) in collaboration with other relevant organizations, shall explore the possibility of developing pilot interprofessional education programs involving medical students and/or resident physicians that are based in the clinical setting and focus on patient safety, communication skills, and elements of systems-based care. (CME Rep. 2, A-02)

D-295.977 Implementation of NBME Clinical Skills Assessment Exam

Our AMA representatives to the Liaison Committee on Medical Education (LCME) will indicate that the teaching and assessment of clinical skills should be a high priority in the accreditation process. (Res. 311, I-01)

D-295.978 Mid-Year and Retroactive Medical School Tuition Increases

(1) Our AMA work with the Association of American Medical Colleges to discourage assessment of mid-year and retroactive increases in medical school tuition and fees.

(2) Our AMA encourage state and county medical societies to develop policy and lobby state legislatures to help minimize medical school tuition increases in public or officially-designated state medical schools.

(3) That medical schools provide entering students with an estimate of their future tuition costs and fees, possibly based on past history of the schools tuition.

(4) Our AMA report back to the House of Delegates at the 2002 Interim Meeting on its progress in limiting mid-year and retroactive tuition increases. (Res. 312, I-01)

D-295.979 Education for the Prevention of Professional Liability Lawsuits

Our AMA will work with members of the Federation and other relevant groups to identify and disseminate information about effective programs for the education of medical students, interns, residents, fellows, and young physicians on the prevention of professional liability lawsuits. (Res. 306, I-01)

D-295.980 Web-Based AMCAS Application

Our AMA: (1) will strongly encourage the Association of American Medical Colleges (AAMC) to create a back-up application system that can be used in the event that the web-based American Medical College Application Service (AMCAS) proves inadequate and by applicants who have limited access to computer resources; (2) will strongly encourage the AAMC to work with medical school Admissions Offices to improve and simplify the web-based medical school application; and (3) work in conjunction with the AAMC to encourage medical schools around the country to remain part of the centralized AMCAS in order to avoid placing an undue burden on future applicants through multiple primary applications. Res. 313, I-01)

D-295.981 Resources for Hepatitis C Prevention

Our AMA will advocate for increased federal funding for hepatitis C research, prevention, and treatment, commensurate with the magnitude of the public health impact of this disease. (Res. 404, A-01)

D-295.982 Model Pain Management Program For Medical School Curricula

Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs. (Res. 308, A-01)

D-295.983 Fostering Professionalism During Medical School and Residency Training

(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements:
(a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.

(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism. (CME Rep. 3, A-01)

D-295.984 Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior

Our AMA will: (1)encourage research and collect information on methods for evaluating the objectives related to professional behavior, and share this information with the medical education community; and (2) offer to work with other organizations, such as the Association of American Medical Colleges, the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Federation of State Medical Boards, and the American Board of Medical Specialties, to develop methods and strategies for the evaluation of professional behavior. (CME Rep. 3, I-00)

D-295.985 Impact of Managed Care on Medical Education

Our AMA, through appropriate in-house committees and other agencies, will study the impact of managed care on medical education and academic centers and present a report at the 2001 Annual Meeting. (Res. 309, A-00)

D-295.986 Evaluating the Impact of Hospital Mergers on Clinical Education for Medical Students and Resident Physicians

Our AMA will study the impact of hospital mergers on access to clinical educational opportunities for medical students and resident physicians. (Res. 310, A-00)

D-295.987 Medical Schools and Colleges not accredited by the liaison committee on medical education or The American Osteopathic Association

Our AMA will work with the Association of American Medical Colleges and other organizations to develop educational materials for pre-medical students and advisors in US undergraduate schools about the difficulties their students may face, including obtaining a residency position, after graduation from medical schools and colleges not accredited by the Liaison Committee on Medical Education or the American Osteopathic Association. (Sub. Res. 304, I-99)

D-295.988 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 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. (CME Rep. 7, I-99)

D-295.989 An Update on the Environment for Medical Students

Our AMA will: (1) ask its representatives to the Liaison Committee on Medical Education (LCME) to request that the LCME collect and make available data on medical schools' progress in defining the standards of conduct in the teacher-learner relationship and on the policies that are implemented to address violations of these standards; (2) encourage medical schools to obtain student opinions about the quality of student services, for example, through review of the responses to the Association of American Medical Colleges Medical School Graduation Questionnaire, and to correct areas that are identified by students as deficiencies; and (3) disseminate this report to medical schools through its Section on Medical Schools and Medical Student Section, to encourage awareness of the importance of issues related to the medical student environment. (CME Rep. 2, I-99)

D-295.990 Nutritional and Dietetic Education for Medical Students

Our AMA will: (1) offer to assist the American Society for Clinical Nutrition in meeting its commitment to ensure that medical schools have appropriate faculty role models to teach clinical nutrition; and (2) identify and disseminate to medical schools new instructional initiatives that heighten the relevance of clinical nutrition content to medical practice. (CME Rep. 1, I-99)

D-295.991 Medical Students Functioning as Phlebotomists

Our AMA will communicate its concerns to the hospital community and other appropriate entities on the need to achieve balance between providing adequate phlebotomy training for medical students and ensuring that medical students are not over-utilized for this purpose by the routine substitution of medical students for phlebotomists or IV technicians. (Sub. Res. 5, I-99)

D-295.992 Development of Courses to Prepare Medical Students and Residents for the Political, Legal and Socioeconomic Aspects of Practice and Physician Advocacy

Our AMA will assist local and state medical societies to develop education programs on the political, legal, and socioeconomic aspects of medical practice and physician advocacy, to be offered to medical students and physicians in residency training throughout the country to supplement their clinical education and prepare them for practice. (Res. 322, A-99)

D-295.993 Grievance and Appeals Process for Physicians-in-Training

Our AMA and its appropriate specialty sections will study physicians-in-training contracts and develop model language for the grievance and appeals process in physicians-in-training contracts. (Res. 301, A-99)

D-295.994 Standardization of MCAT Expiration Period

Our AMA will work with the Association of American Medical Colleges to develop a policy regarding a standardized expiration period for Medical College Aptitude Test scores, allowing for modification of the expiration period if the exam format changes significantly. (Res. 307, A-99)

D-295.995 Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation

Our AMA will urge the Liaison Committee on Medical Education to expand its current accreditation standard to include a nondiscriminatory statement related to all aspects of medical education, and to specify that the statement must address sexual orientation and gender identity. (Res. 305, A-99; Modified: BOT Rep. 11, A-07)

D-295.996 Update on Development of Branch Campuses of International Medical Schools

It is recommended that the AMA take the following actions in lieu of adoption of Resolution 316 (I-98).

(1) Monitor the status of the branch campus of Ross Medical School, and continue to provide information and other appropriate support to the Wyoming Medical Society.

(2) Work with state and county medical societies where new branch campuses of non-U.S. medical schools are being proposed, to provide information to policy makers, the public, potential students, and other interested parties about the role of LCME-accreditation in ensuring educational quality.

(3) Continue to support the WWAMI program as a way to provide access to quality medical education for students who are residents of Wyoming, Alaska, Idaho, and Montana, and as a way to increase the number of physicians who will practice in those states.

(4) Join with the Association of American Medical Colleges in continuing to support the process of voluntary accreditation of medical education programs. (BOT Rep. 25, A-99)

D-295.998 Teaching Professionalism Across the Continuum of Medical Education

Our AMA, through its relevant Councils and Sections, will develop plans and strategies for enhancing the teaching and learning of professionalism as part of medical education. (Res. 318, I-98; Reaffirmed: CME Report 2, A-08)

D-295.999 Extending Impaired Physician Programs to Medical Students

Our AMA will inform students of the variety of options available for treatment of impairment, including medical school and state medical society programs. (CME Rep. 4, I-98; Reaffirmed: CME Report 2, A-08)

D-300.000 Medical Education: Continuing
(See Also: Medical Education; Medical Education: Financing and Support; Medical Education: Graduate)

D-300.983 Financial Conflicts in CME

Our AMA will continue to monitor the implementation of the Accreditation Council for Continuing Medical Education 2004 Standards for Commercial Support and report to the House of Delegates any major evidence that these requirements are or are not effective in ensuring the independence of or adversely impact the availability of continuing medical education. (CME Rep. 13, A-08)

D-300.984 Physician Reentry

Our AMA:

1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.

2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.

3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.

4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs.

5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs:

a. *Accessible: The PREP system is accessible by geography, time and cost.* Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system.

b. *Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing.* Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible.

c. *Comprehensive: The PREP system is comprehensive to maximize program utility.* Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice.

d. *Ethical: The PREP system is based on accepted principles of medical ethics.* Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed.

e. *Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness.* Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians.

f. *Modular: Physician reentry programs are modularized, individualized and competency-based.* They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need.

g. *Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians.* Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation.

h. *Accountable: The PREP system has mechanisms for assessment and is open to evaluation.* Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met.

i. *Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term.* Adequate funding allows

physician reentry programs to operate at sufficient and appropriate capacity.

j. *Responsive: The PREP system makes refinements, updates and other changes when necessary.* Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.

6. Will, as part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting. (CME Rep. 6, A-08)

D-300.985 Revisiting PhRMA Code

1. Our AMA will study the impact of any industry, accreditation or governmental CME guidelines and on accredited CME providers and report back at the 2007 Annual Meeting of the House of Delegates.

2. Our AMA (a) will continue its system for regular communications with state medical society accreditors to monitor the impact of any continuing medical education (CME) guidelines, standards, or applicable regulations on the delivery of CME at the state level, and (b) will continue to monitor trends in financing and availability of CME at all levels with a report back at the 2009 Annual Meeting of the House of Delegates. (CME Rep. 6, A-06; Appended: CME Rep. 5, A-07)

D-300.986 Updated ACCME Standards for Commercial Support

Our AMA will:

(1) create opportunities for ongoing dialogue with AMA members and CME providers to discuss effective mechanisms for resolving conflicts of interest and assuring independent and balanced content in certified CME activities;

(2) communicate actively with the ACCME during the early implementation of the updated Standards for Commercial Support, in such a manner that will ensure workable options for resolving conflicts of interest and bias issues; and

(3) report back to the House at the 2007 Annual Meeting concerning these activities. (BOT Rep. 11, A-05)

D-300.987 Updated ACCME Standards for Commercial Support

Our AMA will (1) communicate actively with the Accreditation Council for Continuing Medical Education regarding the implementation of the updated Standards for Commercial Support, including the Interpretation and Application of Standard 2.3, Resolution of Personal Conflicts of Interest, in such a manner that will ensure workable options for resolving conflicts of interest and bias issues, which will not unfairly or unduly prohibit or impede the free flow of scientific information or discourage participation by physicians in CME activities; and (2) work with ACCME in taking appropriate actions to prevent any future misinterpretation of these guidelines, and report back to the House at the 2005 Annual Meeting. (BOT Rep. 19, I-04)

D-300.988 Implications of the "Stark II" Regulations for Continuing Medical Education

Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits physician compensation without financial limit in the form of continuing medical education that is offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs. (CME Rep. 6, I-04)

D-300.989 Developing a Standardized Letter of Agreement for Use by Accredited CME Programs When Requesting Commercial Support

Our AMA will work with the Accreditation Council for Continuing Medical Education to develop a standardized letter of agreement to be used by all accredited providers when requesting commercial support and the use of the standardized letter of agreement will be incorporated into the accreditation Essentials. (Res. 318, A-04)

D-300.990 CME Validation Criteria

Our AMA (1) will express its support to the American Academy of Family Physicians for its evidence-based continuing medical education initiative and to the Accreditation Council for Continuing Medical Education for its valid clinical content standards; and (2) PRA program will continue to monitor the use of evidence-based standards for CME, reporting back to the House of Delegates as

major changes occur. (CME Rep. 9, A-04)

D-300.991 Web-Based System for Registering CME Credits

(1) Our American Medical Association, through the Division of Continuing Physician Professional Development, will perform a new feasibility analysis to determine if reinitiating the CME Credit Tracker project is possible.

(2) The Council on Medical Education will monitor the progress of the analysis and facilitate constructive dialogue with all interested stakeholders. (CME Rep. 5, A-03)

D-300.992 Internet-Based Continuing Medical Education

(1) Our AMA will express its appreciation to the Accreditation Council for Continuing Medical Education and to the AMA PRA program for anticipating issues associated with Internet-based CME, and for developing clear policy to guide physicians and accredited CME providers in this area.

(2) The Council on Medical Education will remain closely involved with the evaluation processes of the current AMA PRA Internet CME Pilot Project and develop appropriate new language for the certification of AMA PRA category 1 credit for self-directed, self-initiated, Internet-based CME.

(3) The AMA PRA program will continue to monitor the area of Internet-based CME and report back to the House of Delegates as major changes occur. (CME Rep. 4, A-03)

D-300.993 Category 1 CME Credit for Scientific Review

Our AMA shall reconsider authorizing the award of AMA PRA Category 1 credit for prepublication review of articles in peer-reviewed journals, practice guideline development, and grant applications. (Res. 311, A-02)

D-300.994 Reduced Continuing Medical Education (CME) Fees for Retired Physicians

Our AMA will support reduce registration fees for retired physicians at all continuing medical education programs. (Res. 302, I-01)

D-300.995 Reducing Burdens of CME Accreditation and Documentation

Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01)

D-300.996 Model Pain Management Program For Medical School Curricula

Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management. (Res. 308, A-01)

D-300.997 Use of Medical Education Numbers In Continuing Medical Education

Our AMA will disseminate this policy widely and recommend that such policy be adopted by other organizations, including national certification boards and similar entities. (Res. 301, A-01)

D-300.998 Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures

Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner's care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS (CME Rep. 2, A-01)

D-300.999 Registration of Accredited CME Sponsors

Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit. (CME Rep. 4, A-00)

D-305.000 Medical Education: Financing and Support

D-305.963 Securing Medicare GME Funding for Research and Ambulatory Non-Hospital Based Outside Rotations During Residency

Our AMA will:

1. Advocate for the Centers for Medicare and Medicaid Services (CMS) (both federal Medicare and federal/state Medicaid) funding for the time residents and fellows spend in research, didactic activities, and extramural educational activities required for the Accreditation Council for Graduate Medical Education (ACGME) accreditation during their training.

2. Continue to work with organizations such as the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME), to make recommendations to change current Graduate Medical Education (GME) funding regulations during residency training, which currently limit funding for research, extramural educational opportunities, and flexible GME training programs and venues.

3. Monitor any public and/or private efforts to change the financing of medical services (health system reform) so as to advocate for adequate and appropriate funding of GME.

4. Prepare a Council on Medical Education report for the 2009 Interim Meeting that broadly addresses issues of GME funding that includes examples of successful state and regional innovations.

5. Advocate for funding for training physician researchers from sources in addition to CMS such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Veterans Administration, and other agencies. (CME Rep. 4, I-08)

D-305.964 Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion

Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. (Res. 301, A-08)

D-305.965 Alternative Funding for Continuing Medical Education

Our AMA will seek funding for quality, unbiased continuing medical education for all physicians. (Res. 14, A-08)

D-305.966 Reinstatement of Economic Hardship Loan Deferment

Our AMA will actively work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt. (Res. 930, I-07)

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME.

9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08)

D-305.968 CMS to Pay for Residents' Vacation and Sick Leave

Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave. (Res. 321, A-07)

D-305.969 Payment for Graduate Medical Education by the Centers for Medicare and Medicaid Services

Our AMA will work with the Association of American Medical Colleges and other interested groups to prevent reduction in Medicare graduate medical education payments by disallowing reimbursement for the time residents spend in didactic learning. (Res. 317, A-06)

D-305.970 Proposed Revisions to AMA Policy on Medical Student Debt

Our AMA will:

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:
(a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.
(b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
(c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.
(d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.
(e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.
(f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
(g) Support stable funding for medical education programs to limit excessive tuition increases.

2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education. (CME Rep. 13, A-06; Reaffirmation I-08)

D-305.971 Legal Injunction on Medical School Tuition Increases

The AMA will support filing an amicus brief in support of the plaintiff students, if or when *Kashmiri, et al. v. Regents of the University of California* is appealed. (BOT Action in response to referred for decision Res. 833, I-04)

D-305.972 Title VII Funding

Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of $300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues. (Res. 312, A-05; Reaffirmation I-06)

D-305.973 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

Our AMA will work with:

(1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
(a) ensure adequate Medicaid and Medicare funding for graduate medical education;
(b) ensure adequate Disproportionate Share Hospital funding;
(c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
(d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
(e) stabilize funding for pediatric residency training in children's hospitals;
(f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
(g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
(h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and

(2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07)

D-305.974 Funding for Preventive Medicine Residencies

Our AMA will work with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund preventive medicine training programs. (Res. 324, A-05; Reaffirmed: CME Rep. 8, A-08)

D-305.975 Long-Term Solutions to Medical Student Debt

Our AMA will:

(1) through its Council on Medical Education, continue a comprehensive study of medical education financing, with a report back to the House of Delegates at the 2005 Annual Meeting;

(2) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs;

(3) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas;

(4) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; and

(5) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided. (CME Rep. 3, I-04; Reaffirmation I-06)

D-305.976 Federal Student Loan Program Interest Rates

Our AMA will: (1) analyze models of federal student loan and student loan consolidation program interest rate regulations (including fixed and variable rates) and make recommendations to maximize their effectiveness in addressing medical education debt and patient access to health care; (2) utilize data from the study of federal student loan and student loan consolidation program interest rate regulations to enhance its lobbying efforts toward the reauthorization of the Higher Education Act; and (3) report back to the House of Delegates at the 2005 Annual Meeting and the 2006 Interim Meeting regarding the reauthorization of the Higher Education Act of 1965 and any regulations promulgated thereunder. (Res. 729, I-04; Appended and Reaffirmed: BOT Rep. 13, I-05)

D-305.977 Deductibility of Medical Student Loan Interest

Our AMA will work toward 100% tax deductibility of medical student loan interest on federal and state income tax returns. (Res.

705, I-04)

D-305.978 Mechanisms to Reduce Medical Student Debt

Our AMA will:
(1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: (a) eliminating the single holder rule, (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training, (c) retaining the option of loan forbearance for residents ineligible for loan deferment, (d) including, explicitly, dependent care expenses in the definition of the "cost of attendance," (e) including room and board expenses in the definition of tax-exempt scholarship income, (f) continuing the loan consolidation program, including the ability to "lock in" a fixed interest rate, and (g) adding the ability to refinance Federal Consolidation Loans;
(2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;
(3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
(4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;
(5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and
(6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students. (CME Rep. 10, A-04; Reaffirmation I-08)

D-305.979 State and Local Advocacy on Medical Student Debt

Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; (2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives; and (3) study the merits of an annual tuition cap (adjusted for inflation) at public and private medical schools within their states. (Res. 847, I-03)

D-305.980 Immediate Legislative Solutions to Medical Student Debt

Our AMA will: (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including: (a) Elimination of the "single-holder" rule; (b) Continuation of the consolidation loan program and a consolidator's ability to lock in a fixed interest rate; (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship; (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment; (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; and (f) Inclusion of dependent care expenses in the definition of "cost of attendance"; and

(2) lobby for passage of legislation that would: (a) Eliminate the cap on the student loan interest deduction; (b) Increase the income limits for taking the interest deduction; (c) Include room and board expenses in the definition of tax-exempt scholarship income; and (d) Make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001. (Res. 850, I-03; Reaffirmation I-08)

D-305.981 Financing Federal Consolidation Loans

Our AMA will: (1) support the refinancing of Federal Consolidation Loans; and (2) actively advocate for modification of pending and future legislation which that provides the opportunity to refinance Federal Consolidation Loans. (Res. 849, I-03)

D-305.982 Long Term Solutions to Medical Student Debt

Our AMA will: (1) explore membership in the American Council on Education and/or the Committee for Education Financing, in order to build our ties to the higher education community and report back by the 2004 Annual Meeting;
(2) more aggressively publicize existing work done through the Coalition for Student Loan Fairness;
(3) study and report back at the 2004 Interim Meeting on potential new sources of Graduate Medical Education funding and ways to increase resident salaries;
(4) study and report back at the 2004 Interim Meeting on feasible strategies for creating new and/or expanded loan programs specifically for the health professions;
(5) study and report back at the 2005 Annual Meeting on the feasibility of earmarking federal funds to undergraduate medical education for the purpose of reducing medical school tuition at public and private universities;
(6) study and report back at the 2004 Interim Meeting on the need for non-primary-care physicians in underserved areas, with a focus

on showing how the National Health Service Corps and similar loan repayment programs could feasibly be expanded to cover specialties beyond primary care; and
(7) study and report back at the 2005 Annual Meeting on appropriate methods for calculating the value of the clinical work performed by medical students and taking such calculations into account when determining the cost of educating a medical student. (Res. 848, I-03; Reaffirmation I-06)

D-305.983 Strategies to Combat Mid-year and Retroactive Tuition Increases

Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases;
(2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases;
(3) identify and disseminate information about model financial aid programs for medical students that have the potential to reduce student debt;
(4) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students; and
(5) study the funding of medical education programs, to identify:
(a) The status of revenue sources used to support undergraduate and graduate medical education programs, including current constraints on these revenue sources;
(b) Strategies to reduce these financial constraints; and
(c) Mechanisms to ensure that funding for undergraduate and graduate medical education programs is maintained, so as to reduce the financial burden on medical students and resident physicians. (CME Rep. 3, I-03)

D-305.984 Reduction in Student Loan Interest Rates

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% (Res. 316, A-03)

D-305.985 Injunctive Relief Against Mid-Year and Retroactive Medical School Tuition Increases

Our AMA, in collaboration with state, specialty and other interested organizations, will study and report back at the 2004 Annual Meeting on the case precedent, timing, risks, and other considerations in filing for an injunction to block mid-year and retroactive tuition increases occurring after the start of the academic year. (Res. 302, A-03)

D-305.986 Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid

Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools;

(2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid;

(3) ask its Council on Medical Education, Section on Medical Schools, and Women Physicians Congress to consider options to carry out the intentions of current House of Delegates' policy on the issue of spouse and dependent health insurance, dependent care, and dependent living expenses; and

(4) report back on actions taken on this resolution, and their results, to the House of Delegates at the 2004 Annual Meeting. (Res. 301, A-03)

D-305.987 Preserving Medicaid Funding of Graduate Medical Education

Our AMA: (1) continue to monitor the status of funding for graduate medical education by state Medicaid programs and report back to the House of Delegates at the 2004 Interim Meeting: (2) offer support to state and county medical societies and other groups that are working to sustain state funding for graduate medical education under Medicaid; and (3) work with state and county medical societies to advocate for the direct distribution of Medicaid graduate medical education payments to teaching hospitals and/or medical schools and not to third party payers. (CME Rep. 1, I-02)

D-305.988 Strategies to Address Medical School Tuition Increases

Our AMA will: (1) monitor proposals for medical school tuition increases and continue to work with the AMA Medical Student Section and other student groups, along with state and county medical societies, national medical specialty societies and the Association of American Medical Colleges (AAMC) to address the serious issue of rising tuition and medical student debt and to oppose any mid-year or retroactive tuition increases;

(2) encourage medical schools to alert students of the probability of escalation of tuition costs and provide entering students with an estimate of tuition costs for the four years;

(3) encourage federal and state agencies to review and expand options for financial aid (scholarship and loan repayment programs) for medical students, resident physicians, and young physicians by developing programs that address areas of existing and emerging national and local need;

(4) continue to encourage medical schools to provide yearly financial planning/debt management counseling to medical students and the institutions that sponsor residency training to make available similar services for resident physicians;

(5) encourage and work with medical schools to broaden their fundraising activities directed at obtaining revenue for medical student scholarships or for capping/decreasing tuition;

(6) continue to work for a stable funding mechanism for undergraduate medical education;

(7) monitor and report to the House of Delegates at regular intervals, beginning in June of 2004, on progress in limiting medical school tuition and in developing mechanisms to reduce student debt; and

(8) help develop specific strategies to address the problem of mid-year and retroactive tuition increases, and report back at the 2003 Interim Meeting. (CME Rep. 2, I-02; Reaffirmation I-03; Reaffirmation I-06)

D-305.989 Reauthorization and Reversal of Proposed Funding Cuts to Title VII, Title VIII and the Children's Hospital's GME Programs

Our AMA shall reaffirm and support its ongoing efforts to lobby both for the timely reauthorization of the Title VII, Title VIII, and the Children's Hospital's GME Programs and the reversal of funding cuts proposed by the Administration's FY 2003 budget. (Sub. Res. 224, A-02)

D-305.990 Impact of Health System Changes on Medical Education

Our AMA wil continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01)

D-305.991 Tax Deductibility for Student Loan Interest

Our AMA will continue to actively lobby for a minimum inflation-indexed gross income phaseout of $115,000 ($165,000 for joint filers), while continuing to advocate for the elimination of all gross income thresholds. (Res. 244 , A-01)

D-305.992 Accounting for GME Funding

Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education. (Sub. Res. 302, I-00)

D-305.993 Medical School Financing, Tuition, and Student Debt

(1) The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing a web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.

(2) Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.

(3) Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

(4) Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.

(5) Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.

(6) Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.

(7) Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans. (CME Rep. 2, I-00; Reaffirmation I-03; Reaffirmation I-06)

D-305.994 Postgraduate Medical Education Reimbursement

Our AMA: (1) will study the formula for funding graduate medical education that is used by Medicare, and make recommendations to ensure that all sites where resident physicians are trained are included in the funding formula; and (2) policies related to the mechanisms for the funding of graduate medical education be reviewed and, if appropriate, be consolidated. (Sub. Res. 301, A-00)

D-305.995 Physician Workforce Planning and Physician Retraining

(1) Our AMA will raise the awareness of groups using the model of adjusting entry-level residency positions to control the physician workforce of the substantial effect of retraining and changes in choice of specialty training on the number of filled entry-level positions.

(2) Our AMA will collect data on access to health care by specialty and geographic location to assist in ongoing workforce planning initiatives.

(3) A new model for workforce planning be developed to address the needs of the public for access to health care and the subsequent impact on the needs of teaching institutions to maintain the quality of their educational programs in considering the number of entry-level residency positions. (CME Rep. 2, A-00)

D-305.996 Coding for Services Involving Teaching Activity

Our AMA will continue: (1) its efforts to develop the next generation of CPT coding, with attention to the coding needs of teaching physicians; and (2) to work with the Association of American Medical Colleges and CMS to clarify and minimize the documentation requirements for teaching physicians. (BOT Rep. 7, A-99)

D-305.997 Training of Physicians Under Managed Care

Our AMA will: (1) monitor ongoing legislative initiatives and support specific language that would preserve the opportunities for medical students and resident physicians to participate in the care of patients under the supervision of the responsible attending staff; (2) monitor and promote mutually beneficial private initiatives between managed care organizations and educational entities that would preserve the opportunities for medical students and resident physicians to participate in the care of patients under the supervision of the responsible attending staff; and (3) ask the Liaison Committee on Medical Education to survey those medical schools and academic health centers with managed care contracts for the presence of exclusion provisions that curtail the education of medical students and resident physicians. (CME Rep. 4, A-99)

D-305.998 Impact of the Balanced Budget Act of 1997 on Graduate Medical Education Funding in Non-Hospital Settings

Our AMA will continue to advocate for additional funds from the federal government and other third party payers for GME programs that take place in non-hospital settings. (BOT Rep. 5, I-98; Reaffirmed: CME Report 2, A-08)

D-310.000 Medical Education: Graduate

D-310.961 Use of At-Home Call by Residency Programs

1. Our AMA encourages the Accreditation Council for Graduate Medical Education to collect data on at-home call by specialty from

both program directors and from residents and fellows and to release these aggregate data annually to the Graduate Medical Education community.
2. Our AMA and the ACGME will collaborate on a survey (similar to those conducted by the AMA in 1989 and 1999) on the educational environment of resident physicians, encompassing all aspects of duty hours, including at-home call.
3. Our AMA will ask that the Council on Medical Education incorporate a review of at-home call issues in the duty hours follow-up report due at the 2010 Annual Meeting.
4. Our AMA will define "at-home" call and its appropriate or inappropriate uses, allowing for flexible solutions from one specialty to the next, with a report back to the House of Delegates.
5. Our AMA encourages the ACGME and the GME community to examine the effects of the increased use of at-home call on resident education and supervision and develop appropriate standards to ensure that appropriate education and supervision is maintained, regardless of the setting. (CME Rep. 5, I-08)

D-310.962 Evaluation of Increasing Resident Review Committee Requirements

Our AMA will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. (Res. 315, A-08)

D-310.963 Family and Medical Leave Act Policies for Residents and Fellows

Our AMA:

1. Encourages the Accreditation Council for Graduate Medical Education to study the feasibility of requiring training institutions to offer paid FMLA-qualified leave for residents of no less than six weeks' duration, and to permit unpaid FMLA-qualified leave of an additional six weeks.

2. Will propose to the American Board of Medical Specialties member boards that they standardize their policies regarding parental leave, absence from training, and the timing of entrance into the board certification examination process, so that at a minimum, all residents are allowed six weeks' absence of training for FMLA-qualified leave per academic year without disproportionately increasing the length of training, or postponing certification.

3. Opposes requiring residents to serve any more service time than they took in leave that qualifies under the federal Family and Medical Leave Act.

4. Will convene a group of appropriate interested parties, including the ACGME and the ABMS, to discuss options for standardization of FMLA-qualified leave policies that would not disproportionately increase length of training or result in postponement of certification. (CME Rep. 11, A-08)

D-310.964 Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety

Our AMA:

1. Reaffirms support of the current Accreditation Council for Graduate Medical Education duty hour standards.

2. Continues to monitor the enforcement and impact of the ACGME duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and will monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back at the 2010 Annual Meeting of the AMA House of Delegates.

3. Will, as part of its Initiative to Transform Medical Education strategic focus, utilize relevant evidence on patient safety and sleep to develop a learning environment model that optimizes balance between resident education, patient care, quality and safety, and report back at the 2010 Annual Meeting.

4. Will review, evaluate, and publicize the work of the ACGME Committee on Innovation, in particular its pilot projects related to duty hours, and will encourage participation by ACGME Residency Review Committees and residency programs in these and other efforts towards innovation and improvement in graduate medical education and patient safety.

5. Will ask the ACGME to consider offering programs/institutions additional incentives, such as longer accreditation cycles or reduced accreditation fees, to ensure programmatic and institutional compliance with duty hour limits.

6. Encourages publication of studies about the effects of duty hour standards, extended work shifts, hand offs and continuity of care procedures, and sleep deprivation and fatigue on patient safety, medical error, resident well-being, and resident learning outcomes, and will disseminate study results to GME designated institutional officials (DIOs), program directors, resident/fellow physicians,

attending faculty, and others.

7. Will communicate to all GME DIOs, program directors, resident/fellow physicians, and attending faculty about the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and ethics.

8. Will use the GME e-Letter, AMA Resident and Fellow Section publications, and other communications vehicles to raise awareness among residents (particularly first-year residents) of the ACGME and its role in monitoring and enforcing duty hours.

9. Council on Medical Education will closely monitor the progress of the Institute of Medicine (IOM) committee studying resident duty hours and patient safety and to respond, and/or assist the AMA Washington Office in responding, to any legislative or regulatory initiatives that arise from the IOM or other bodies.

10. Urges the ACGME and AOA to decrease the barriers to reporting duty violations and resident intimidation. (CME Rep. 5, A-08)

D-310.965 Credentialing Materials: Timely Submission by Residency and Fellowship Programs

Our AMA: (1) encourages residency programs and fellowship programs to properly complete and promptly submit verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request; and (2) encourages the Accreditation Council for Graduate Medical Education to add to the accreditation standards for residency and fellowship programs and to the Institutional Program Requirements the requirement of the proper completion and prompt submission of verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request. (Res. 311, A-08)

D-310.966 Employment Benefits for Residents and Fellows

Our AMA will, through its appropriate sections, study the status of employment benefits offered to residents and fellows and report back at the 2010 Annual Meeting. (CME Rep. 14, A-08)

D-310.967 Resident Pay During Orientation

Our AMA will: (1) advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities; and (2) ask the Accreditation Council for Graduate Medical Education to amend its institutional requirements so that institutions are required to compensate resident and fellow physicians, and provide benefits, for time spent in required orientation activities at a level commensurate with the pay that the resident or fellow shall receive while in their program. (Res. 302, A-07)

D-310.968 Intern and Resident Burnout

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents and fellows.

2. Our AMA will work with other interested groups to regularly inform Graduate Medical Education designated institutional officials program directors, resident physicians, and attending faculty about resident/fellow burnout (including recognition, treatment, and prevention of burnout) through such media as the AMA's GME e-Letter.

3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents/fellows.

4. Our AMA will encourage further studies and disseminate the results of studies on physician burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements, with a report back at the 2009 Interim Meeting of the AMA House of Delegates. (CME Rep. 8, A-07)

D-310.969 Fellowship Application Reform

Our AMA will:
(1) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing a plan to standardize the application and selection process for specialty and subspecialty fellowship training;
(2) report back to the House of Delegates at the 2009 Annual Meeting on progress towards the goal of standardizing the application and selection process for specialty and subspecialty fellowship training; and

(3) encourage all subspecialties to use the same application cycle and such application cycle should not commence before 12 months in advance of the resident starting the fellowship, when feasible. (CME Rep. 3, A-07)

D-310.970 Improving Parental Leave Policies for Residents

Our AMA will study and encourage the Accreditation Council for Graduate Medical Education's participation in such study of (1) the feasibility of considering guaranteed paid maternity leave for residents of no less than six weeks duration, with the possibility of unpaid maternity leave of an additional six weeks; (2) written leave policies for residents for paternity and adoption; and (3) the effect of such maternity, paternity, and adoption leave policies on residency programs, with report back to the House of Delegates at the 2008 Annual Meeting. (Res. 303, A-07)

D-310.971 The Residency Physician Shortage Reduction Act of 2007

Our AMA will vigorously support in its national legislative activities the passage of pending and future legislation which will increase physician residency positions throughout many states while not undermining existing physician residency positions in any of the states. (Res. 204, A-07; Reaffirmation I-07)

D-310.972 Protection Against Delayed Residency Program Closure

Our AMA will:

(1) Work closely with the Accreditation Council for Graduate Medical Education to contribute to, review and comment on any new ACGME policies related to residency closures, regardless of cause.

(2) Work with the American Board of Medical Specialties to encourage all its member certifying boards to develop a mechanism to accommodate the discontinuities in training which arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.

(3) Work with the ACGME to monitor closing programs, including encouraging programs to immediately notify residents of pending closures and to promptly transfer residents to alternate accredited programs as soon as feasible with the least disruption to training; and strongly encourage programs which accept transferred residents to minimize extensions to total training time.

(4) Use the National GME Census and work with the ACGME to assess how much disruption occurred in the training of residents as a result of program closures caused by Hurricane Katrina and report back at the 2009 Annual Meeting with further recommendations.

(5) Work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure. (CME Rep. 7, A-06)

D-310.973 Enforcement of ACGME Duty Hour Standards

Our AMA will:

(1) Continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards, as they relate to the larger issues of optimal patient care and learning environment for residents, with a report back at the 2008 Annual Meeting of the AMA House of Delegates.

(2) Encourage and disseminate the results of studies that link compliance with duty hours standards to patient care quality and medical errors, as well as to resident learning and professionalism.

(3) Work with other interested groups to regularly inform GME designated institutional officials (DIOs), program directors, resident physicians, and attending faculty about the adverse effects of sleep deprivation and fatigue on patient safety and resident well-being.

(4) Work with the ACGME to improve the reporting mechanisms for duty hour violations in order to better protect resident confidentiality and improve the learning environment. (CME Rep. 4, A-06)

D-310.974 Policy Suggestions to Improve the National Resident Matching Program

Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective

implementation; and (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants. (CME Rep. 15, A-06)

D-310.975 Fellowship Application Reform

Our AMA will:

(1) encourage the Electronic Residency Application Service, the National Resident Matching Program, the San Francisco Matching Program, the Council of Medical Specialty Societies and its member organizations, and the American Board of Medical Specialties and its member medical specialty boards to develop a plan to standardize the application and selection process for each specialty. The plan should assure that:
(a) the process provides adequate time for the resident to be exposed to all subspecialties within a specialty before he/she must apply to a fellowship training program;
(b) a consistent application and match process and timeline is adopted across all available subspecialties within each specialty; and
(c) a process is developed which gives both applicants and programs ample time to evaluate each other before generating their ranking lists; and

(2) report back to the House of Delegates at the 2007 Annual Meeting on progress toward achieving a standardized application and selection process for fellowship training positions. (CME Rep. 6, A-05)

D-310.976 Negative Impact on Surgical and Procedural Education from Revised CMS Interpretive Guidelines for Informed Consent

Our AMA will:

(1) cooperate with other interested parties to strongly express its concerns regarding the potentially negative impact on medical education of Sections 482.24(c)(2)(v) and 482.51(b)(2) of the Centers for Medicare and Medicaid Services (CMS) State Operations Manual based on the May 21, 2004 revisions;

(2) cooperate with other interested parties to encourage CMS to immediately revise or further clarify Sections 482.24(c)(2)(v) and 482.51(b)(2) of the CMS State Operations Manual and communicate to CMS our desire to assist in the development of new language which both protects patient autonomy and preserves the appropriate flexibility of attending physicians in the teaching environment; and

(3) strongly discourage JCAHO from adopting language in its accreditation standards similar to language in Sections 482.24(c)(2)(v) and 482.51(b)(2) of the CMS State Operations Manual based on the May 21, 2004 revision. (Res. 321, A-05)

D-310.977 National Resident Matching Program Reform

Our AMA will:

(1) work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;

(2) actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;

(3) request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

(4) continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises; and

(5) work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians. (CME Rep. 4, A-05)

D-310.978 Enforcement of ACGME Duty Hours Standards

Our AMA will:

(1) continue to monitor the enforcement of the Accreditation Council for Graduate Medical Education duty hour standards, including the consistency, accuracy, and validity of reporting, and report back at the 2006 Annual Meeting;

(2) work with other interested groups to assist residency programs in educating resident physicians and attending faculty about the adverse effects of sleep deprivation and fatigue on patient safety and resident well-being;

(3) strongly encourage Residency Review Committees to ensure that site visits include meetings with peer-selected or randomly-selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor;

(4) recommend to the ACGME that the Common Program Requirements be amended to charge program directors, along with the designated institutional official, with the responsibility of creating an environment where resident physicians, without fear of retaliation, may make complaints and report noncompliance with ACGME standards, including duty hours;

(5) investigate ways to protect resident physicians who file a complaint to the ACGME, and report back at the 2006 Annual Meeting; and

(6) encourage and disseminate the results of studies that link compliance with duty hour standards to patient care quality outcomes and patient safety. (CME Rep. 1, I-04)

D-310.979 International Medical Graduate Application for National Resident Matching Program

Our AMA will ask the Electronic Resident Application Service to review the pricing structure for applicants applying to numerous residency sites and specialties. (Res. 315, A-04)

D-310.980 Increase in ACGME Fees

Our AMA will work with the Accreditation Council for Graduate Medical Education to limit the increase of the ACGME fees. (Res. 311, A-04)

D-310.981 Resident/Fellow Work and Learning Environment

(1) Our AMA will, with the input of other groups involved in medical education, pursue the creation and dissemination of a survey in 2005 to medical students, resident physicians, and attending faculty to determine the effects of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hours standards on the clinical learning environment, with the scope of future surveys on the learning environment to be determined based on the results of the 2005 survey; and (2) our AMA and other relevant groups will offer to work with the ACGME in the design and analysis of the ACGME resident survey. (CME Rep. 8, A-04)

D-310.982 Protecting the Privacy of Physician Information Held by the ACGME

Our AMA will request the Accreditation Council for Graduate Medical Education and any other organization with a similar case and procedure log for resident physicians to (1) develop and implement a system to remove or sufficiently protect identifying data from individual physicians' data logs; and (2) adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician. (Res. 301, A-04)

D-310.983 Measure Effectiveness of AMA Anti-Discrimination Policy

Our AMA will continue to collect data on international medical graduate participation in graduate medical education, monitor trends, and disseminate the findings widely, for example, through publication in the annual Medical Education Issue of the Journal of the American Medical Association. (CME Rep. 7, A-04)

D-310.984 Resident/Fellow Work and Learning Environment

Our AMA will: (1) ask the Board of Directors of the Accreditation Council for Graduate Medical Education to reconsider the changes made in the Common Program Requirements for duty hours and the procedures for the approval exemptions at their meeting of February 11, 2003, and approve the original language and intent from June 2002 prior to the implementation of requirements on July 1, 2003;

(2) study all options to address enforcement and compliance with the ACGME Duty Hour requirements (Joint Commission of Accreditation of Healthcare Organizations, legislation, private methods, etc.) with a report back to the House of Delegates at the 2004 Annual Meeting;

(3) study, develop, and promote a method of creating an environment for residents to safely report violations on resident duty hours without any repercussions;

(4) request an annual report to ACGME's Member Organizations from the ACGME, which includes the number of complaints received, the number not in compliance due to duty hours and working conditions and the action taken by ACGME, and that this report be indexed by specialty; and

(5) continue to work with the ACGME to refine the duty hours standards, and work with ACGME and other appropriate entities to collect evidence on the impact of current standards in regards to patient and resident safety, resident education, and eliminating fatigue and sleep deprivation. (Res. 322, A-03)

D-310.985 Measure Effectiveness of AMA Anti-discrimination Policy

Our American Medical Association will utilize the existing Graduate Medical Education Census, with the assistance of the International Medical Graduates Section to examine trends and patterns in the selection of international medical graduates by residency program directors, and report back to the House of Delegates at the 2004 Annual Meeting.

Our AMA will utilize the GME E-letter to communicate its policies of anti-discrimination to all residency program directors. (Res. 308, A-03)

D-310.986 Accreditation Council for Graduate Medical Education Enforcement of Duty Hour Standards

Our AMA will: (a) continue to work with the Accreditation Council for Graduate Medical Education (ACGME) to further refine the standards for resident physician duty hours and to collect additional evidence on the impact of the current standards with respect to preserving the quality of resident physician education and eliminating fatigue and sleep deprivation;

(b) continue to strongly encourage the ACGME to vigorously enforce its accreditation standards regarding resident physician duty hours;

(c) request that an annual report be provided to the Member Organizations of the ACGME (AMA, American Association of Medical Colleges, American Board of Medical Specialties, American Hospital Association, Council of Medical Specialty Societies) on the number of programs by specialty that were not in compliance with resident physician duty hour standards and the action taken by the ACGME;

(d) continue to monitor the enforcement of ACGME standards on resident physician duty hours and report back to the House of Delegates as soon as possible, but no later than the 2004 Interim Meeting and regularly thereafter; and

(e) work with the ACGME to objectively evaluate the impact of the new standards for resident work hours upon patient care and safety.

(2) The Council on Medical Education will continue to explore all possible approaches to the enforcement of duty hours and the protection of residents who report duty hour violations and report its findings to the ACGME Task Force on Duty Hours for its consideration. (CME Rep. 6, A-03)

D-310.987 Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety

Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians. (Res. 314, A-03)

D-310.988 Investigation into the Contribution of Medicare+Choice Programs to Graduate Medical Education Funding

Our AMA will take appropriate action to ensure that funding for graduate medical education from Medicare+Choice programs is being distributed as allocated to the nation's teaching hospitals. (Res. 301, A-02)

D-310.989 Resident Physician Working Conditions

(1) As continued evidence is developed and collected regarding resident work hours, patient safety, resident well-being, and resident education, resident physician total duty hours shall be reassessed. (2) Our AMA shall: (a) strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to vigorously enforce the common accreditation standards adopted by their Board of Directors on June 11, 2002 regarding resident duty hours; and (b) requests that ACGME provide the AMA with a report on the number of programs by specialty that were required to provide immediate progress reports to Residency Review Committees and the Institutional Review Committee as well as the number of programs for which resident surveys and focused follow-up visits were conducted, beginning with the period of July 1, 2001-June 30, 2002 and then on an annual basis. (CME Rep. 9, A-02)

D-310.990 Resident/Fellow Work and Learning Environment

Our AMA will: (1) work with organizations such as the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other appropriate organizations, toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms; and (2) encourage the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patient safety and to explore possible solutions to the problem of work hours and conditions. (Res. 310, I-01)

D-310.991 Intern and Resident Working Hours

The ACGME: (1) through its Residency Review Committees (RRC) and the Institutional Review Committee, enforce work hour guidelines rigorously and ensure compliance with work hour standards; and (2) be requested to investigate mechanisms to provide readily accessible, timely and accurate information about work hours for individual programs that is not constrained by the cycle of survey visits. (CME Rep. 1, I-01)

D-310.992 Limits on Training Opportunities for J-1 Residents

Our AMA will request that the Bureau of Educational and Cultural Affairs, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties and the Educational Commission for Foreign Medical Graduates develop criteria by which J-1 exchange visitor physicians could seek extension of the length of their visa beyond the 7-year limit in order to participate in fellowship or subspecialty programs accredited by the ACGME. (Res. 303, A-01)

D-310.993 Fair Process for Physicians-In-Training

Our AMA will distribute to Graduate Medical Education programs the model resident contract language for fair process set forth in this report, for use in establishing procedures in conformity with the Institutional Requirements of the American College of Graduate Medical Education and the CEJA Opinion on Due Process (9.05). (BOT Rep. 19, A-01)

D-310.994 Intern and Resident Work Standards

Our AMA: (1) will support the various standards of Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committees as a template for reasonable resident work conditions, pending further data; (2) will stress the consideration of patterns and trends of program violations of ACGME requirements, and affirm the recommendations of Council on Medical Education Report 3, A-00, that recommended various alternatives to enforce compliance with requirements, including the shortening of the cycle for review of programs that receive unfavorable Institutional Reviews; and (3) through its Council on Medical Education, will work with the American Academy of Sleep Medicine to convene a meeting during 2001 on the evidence available about the effect of chronic fatigue and acute sleep deprivation on medical education and physician performance and prepare a consensus statement on areas for further research and effective mechanisms to address identified concerns. (Sub. Res. 306, I-00)

D-310.995 Enforcement of ACGME Requirements

(1) The ACGME be asked to distribute the alternatives suggested in this report to each of the Residency Review Committees (RRC) and the Institutional Review Committee for their consideration and comment as mechanisms to enforce compliance with requirements.

(2) Our AMA representatives be requested to ask the ACGME and the RRCs to discuss mechanisms included in this report to enhance the enforcement of Institutional and Program Requirements without increasing the risk of the withdrawal of accreditation.

(3) Our AMA representatives be requested to ask the ACGME and the RRCs to determine any additional information regarding program evaluations that can be added to the ACGME web site and that they encourage the ACGME to simplify that web site to facilitate the retrieval of information.

(4) Our AMA, through the Medical Student Section and the Resident and Fellow Section, will provide medical students and residents a guide to interpreting the ACGME Web site as it relates to the various levels of accreditation and the length of the survey cycle. (CME Rep. 3, A-00)

D-310.996 Compliance with Resident Work Hour Requirements

(1) ACGME will be asked to collect and report annually the number and variety of violations of duty-hour requirements identified by each Residency Review Committee (2) Our AMA will study the impact of prolonged work hours, including moonlighting, on resident physician performance and well-being. (CME Rep. 5, I-99)

D-310.997 Compliance with National Resident Matching Program Requirements by Residency Program Directors

(1) Our AMA will distribute to medical students (via the Medical Student Section) copies of the forthcoming National Resident Matching Program (NRMP) brochure summarizing NRMP policies and procedures.
(2) Our AMA will distribute to medical students (via the Medical Student Section) information about the process for reporting violations of NRMP policies and procedures.
(3) Our AMA will continue to monitor the issue and report back to the House of Delegates on progress in reducing the number of violations, either through the annual report on medical education or, if warranted, in a separate report.
(4) Organizations of program directors be included in future discussions of violations of NRMP policies and procedures. (CME Rep. 4, I-99)

D-310.998 Medical Education Financing

Our AMA: (1) in consultation with the Medical Student Section, will prepare a comprehensive report on medical education financing to examine methods of decreasing the cost of medical education to students, specifically including tuition reduction, tuition caps, increasing grants, and subsidized loans, investigating legislative and school-based aid options; (2) will develop strategies to ensure adequate funding for medical schools; and (3) will develop reports on (a) reducing the cost of medical education to students and (b) medical school financing, and that these reports be presented to the House of Delegates at I-2000. (Res. 308, I-99)

D-310.999 Clinical Supervision of Resident Physicians by Non-Physicians

In light of the concerns of the AMA Resident Physician Section and the adoption of amended Principle 16, the ACGME be asked to clarify ACGME Institutional and Program Requirements regarding the responsibility for resident supervision. (CME Rep. 3, A-99; Reaffirmed: Res. 322, A-03)

D-315.000 Medical Records and Patient Privacy

D-315.982 AMA's Prescribing Data Restriction Program "Opt-Out" Policy

Our AMA will add to the current Prescribing Data Restriction Program "opt-out" disclaimer, patient and physician benefits for restricting use of prescribing data to pharmaceutical sales representatives. (Res. 606, I-06)

D-315.983 Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data

Our AMA will continue to monitor the economic implications of the secondary sale and use of non-identifiable, aggregate data. (CMS Rep. 6, I-06)

D-315.984 Ownership of Claims Data

Our AMA will:
(1) encourage physicians to include language designed to buttress rights associated with claims data ownership and access when contracting with health plan payers and other third parties;
(2) continue to educate physicians on providing public and private health plan payers the "minimum necessary," as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations thereunder, protected health information necessary to achieve the purpose of a disclosure;
(3) assist physicians wishing to register a complaint against health plan payers that have used claims data to form a database, or that have permitted access to or sale of the database or its contents without explicit patient and/or physician authorization, beyond the scope permitted by HIPAA with the Department of Health and Human Services Office of Civil Rights;
(4) advocate to the Department of Health and Human Services, Office of the National Coordinator of Health Information Technology and/or other appropriate agencies for rules and regulations ensuring appropriate physician ownership and access rights to claims data, and appropriate protection of claims data held by various parties;
(5) continue to monitor federal and state activities impacting the exchange of physician-generated health information, including claims data; and
(6) continue to strengthen opportunities for physician ownership of and access to patient claims data, create model contract language to assist physicians in strengthening their rights in this area, and report back to the House of Delegates on the status of these activities. (BOT Rep. 19, I-06)

D-315.985 Electronic Medical Record and Privacy Protections

Our AMA will develop policy regarding use, patient control, and privacy of patient information in the electronic medical record. (Res. 709, A-06)

D-315.986 Guiding Principles, Collection and Warehousing of Electronic Medical Record Information

Our AMA will: (1) develop guiding principles for the collection, warehousing, and use of electronic medical record information and claims data by third parties, including clearinghouses, other vendors, and payers; (2) explore the development of a claims data warehouse or clearinghouse for physicians, and report back at the 2006 Annual Meeting on its progress; and (3) explore the development of an electronic medical record repository for use by all physicians that adheres to existing AMA policies on core data standards, and confidentiality, integrity and security of patient medical record information, and that our AMA, recognizing that the cost of implementing the foregoing resolutions could be substantial, look into funding mechanisms to implement the directives as outlined. (Res. 802, I-05)

D-315.987 Patient Confidentiality and the USA Patriot Act

Our AMA will:

(1) study the potential impact of the USA Patriot Act on patient confidentiality;

(2) develop recommendations for physicians who are contacted for information about patients pursuant to provisions of the USA Patriot Act;

(3) advocate for such modifications to the USA Patriot Act as may be necessary to protect patient confidentiality and minimize legal liability for physicians;

(4) advocate that Section 215 of the USA Patriot Act sunset as scheduled, or, if the Act is reauthorized, for amendments to Section 215 in accordance with the recommendations presented in Board of Trustees Report 29-A-05;

(5) develop educational materials to inform physicians of the federal disclosure requirements of the Patriot Act as amended in 2006; and

(6) advocate for further amendments to the Patriot Act, including the repeal of the one year non-disclosure order. (BOT Rep. 29, A-05; Appended: BOT Rep. 16, A-07)

D-315.988 Use of Physician and Patient Prescribing Data in the Pharmaceutical Industry

Our AMA will (1) work to control the use of physician-specific prescribing data by the pharmaceutical industry as follows: (a) implement a suitable "opt-out" mechanism for the AMA Physician Masterfile governing the release of physician-specific prescribing data to pharmaceutical sales reps by including appropriate restrictions in the AMA data licensing agreements; (b) communicate to physicians the resources available to them in reporting inappropriate behavior on the part of pharmaceutical sales representatives and the work the AMA has done and will continue to do on their behalf; and (c) work with Health Information Organizations (HIOs) to describe to physicians how their prescribing data are used and work to create access for physicians to view reports on their own prescribing data to enhance their clinical practice; and (2) assume a leadership position in both developing a Prescribing Data Code of Conduct for the Pharmaceutical Industry that dictates appropriate use of pharmaceutical data, behavior expectations on the part of industry, and consequences of misuse or misconduct, and in convening representatives from HIOs and the pharmaceutical companies to promulgate the adoption of the code of conduct in the use of prescribing data. (BOT Rep. 24, I-04; Reaffirmed in lieu of Res. 624, A-05)

D-315.989 Protecting Patient Privacy Against Federal, State or Local Governmental Intrusion

Our AMA will (1) communicate to the President and the US Department of Justice our concern over the recent issuing of subpoenas by the US Department of Justice for the private medical records of any patient, including those patients who have had miscarriages and abortions; and (2) oppose federal, state or local governmental entity intrusions on the patient-physician relationship and oppose any request by such entities for confidential patient medical records without valid legal justification and authority or without appropriate patient authorization. (Sub. Res. 206, A-04; Amended: BOT Action in response to referred for decision Resolve 2 of Sub. Res. 206, A-04)

D-315.990 Physician Patient Privilege

Our AMA will: (1) periodically inform its members of their legal responsibilities relating to the confidentiality and release of privileged patient information under applicable federal law; and (2) develop model consent forms to be used by physicians. (Res. 10, A-02)

D-315.991 Medical Records with Bills

Our AMA shall cause to be introduced legislation that would: (1) establish criteria defining when the request for medical records from a third party payer is appropriate, and (2) require insurance companies to pay for copied medical records requested by said insurance company at the rate established by law. (Res. 218, A-02)

D-315.992 Police, Payer and Government Access to Patient Health Information

Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians. (Res. 246, A-01)

D-315.993 Physicians as Patients: their Right to Confidentiality

Our AMA will consider for possible intervention pending and future court cases in which the principles of informed consent are inappropriately expanded to require disclosure of a physician's impairment, including substance abuse problems, or information otherwise protected by laws governing patient privacy and confidentiality. (BOT Rep. 17, I-99)

D-315.994 Abuse of the Medical Record for Regulation or Financing the Practice of Medicine

Our AMA will develop a public education campaign to inform the American public of the importance of maintaining the confidentiality of the Medical Record (Res. 820, A-99)

D-315.995 Breach of Confidentiality of the Doctor-Patient Relationship by Self-Insuring Employers

(1) Our AMA will study the issue of the breach of confidentiality of the doctor-patient relationship by self-insuring employers, especially the use of confidential medical records and claims information in employment decisions by the employer.(2) That should such study reveal instances where there is possible breach of confidentiality, or a possible breach of doctor-patient relationship by self-insuring employers, the AMA should work with appropriate business and regulatory authorities, agencies and associations to stop such practices. (3) A report on the study and appropriate actions be brought back to the House of Delegates at I-99. (Res. 801, A-99)

D-315.996 Interim Report of the Inter-Council Task Force on Privacy and Confidentiality

Our AMA: (1) will strongly supports the voluntary adherence of all Institutional Review Boards (IRBs) to the standards of the Common Rule (45 CFS 46), regardless of whether or not the institution receives federal funding;

(2) will continue to advocate aggressively for prohibitions on the sale and exchange of personally identifiable health information for commercial purposes in the absence of explicit authorization from the patient;

(3) will continue to advocate for federal preemption that establishes a 'floor' in legislation on patient privacy and confidentiality, rather than a 'ceiling,' subject to review if the AMA is satisfied that adequate patient safeguards are assured by specific proposed legislation;

(4) to facilitate research done with subjects from more than one state while continuing to protect patients, our AMA should develop model state legislation on privacy and confidentiality;

(5) will advocate for legislative action to repeal the pertinent section of the "Health Insurance Portability and Accountability Act of 1996" that mandates the establishment of a Unique Patient Identifier; and .

(6) Inter-council Task Force on Patient Privacy and Confidentiality continue to address unresolved issues relating to patient privacy and confidentiality with particular attention to public health and epidemiology issues and requirements, and report its recommendations at I-99 (BOT Rep. 36, A-99)

D-315.997 Preservation of Medical Records

Our AMA will: (1) work with other appropriate organizations to further study and develop principles and criteria for the retention of medical records; and (2) monitor progress in information technology leading to development of a practical and secure personal electronic medical record. (CSA Rep. 8, I-98; Reaffirmation A-04)

D-315.998 Standard Format for Date and Drug Identifiers in Medical Transactions and Medical Records Keeping

(1) Our AMA will continue its vigorous efforts to participate in and provide the physician viewpoint in regard to the development of

electronic medical records standards.

(2) In connection with its efforts related to electronic medical records that the AMA recommend a standard way to designate dates and the identity of drugs prescribed for patients.

(3) When determining its recommendation on the appropriate data element for designating dates, the AMA consider options which include use of an ISO standard date format as follows: year (four digits)-month (two digits)-day (two digits) (e.g. 1998-09-25).

(4) When determining its recommendation on the appropriate data element for designating drugs prescribed for patients, the AMA consider options which include the use of a standardized National Drug Code (NDC) number assigned to each drug by the FDA. (Res. 518, I-98; Reaffirmation A-04)

D-320.000 Medical Review

D-320.992 Notification, Precertification, and Appeals for Medications and Imaging Studies

Our AMA will seek to have all notifications, precertifications and appeals for medications and imaging studies allowed equally by phone, e-mail, fax or letter. (Res. 132, A-07)

D-320.993 Insurance Coverage Appeals

Our AMA will:

(1) continue to update and promote the AMA Campaign to Promote Independent External Review and AMA Campaign to Preserve Physicians' Role in Medical Necessity Determinations and support the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of the health plan documentation requirements, such as the appeal process;

(2) continue to advocate to ensure that physicians receive prompt, fair payment from health plans through educational products, seminars and advocacy efforts;

(3) continue to encourage health plans to implement online appeal processes to reduce the administrative burden and cost to physicians and their patients when claims are denied inappropriately;

(4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes;

(5) remain an active participant in the standards development activities of several standards development organizations and data content committees; and

(6) continue in its leadership role in the National Uniform Claims Committee and its work with the standards development organizations. (BOT Rep. 23, A-06)

D-320.994 Inadequate Specificity of Claims Rejection

Our AMA will make it clear that existing error messages are generally inadequate, and work with third party payers, particularly those with electronic payment systems, to establish claims rejection codes which specify the particular data element in question, identify the specific deficiency in maximum detail, and refer to legends which explain themselves unambiguously. (Res. 706, I-01)

D-320.995 Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans

(1) Our AMA will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization. (2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims, (b) seek information on a regular basis from those associations that collect such information, and (c) respond with appropriate legislation, advocacy, and communication initiatives. (CMS Rep. 5, I-00)

D-320.996 Managed Care Organization Retrospective Denial Rates

Our AMA will study the reasons for and the rate of managed care retrospective payment denials or down-coding for care provided, the dollar value involved, and the effect of these practices on patients, physicians, hospitals and other entities. (Sub. Res. 709, I-99)

D-320.997 Clinical Practice Guidelines and Clinical Quality Improvement Activities

The Clinical Practice Guidelines Recognition Program become fully operational, with a status report on the program provided at the 2000 Annual Meeting. (BOT Rep. 6, A-99)

D-320.998 Denial of Care and Appeal Mechanisms by Managed Care Companies

Our AMA will study the true existence and extent of managed care denials of care and appeals to independent review entities. (Res. 708, A-99)

D-330.000 Medicare

D-330.922 Competitive Bidding for Purchase of Medical Equipment by Centers for Medicare and Medicaid Services

Our AMA will: (1) lobby in favor of modification of current Centers for Medicare & Medicaid Services policy to ensure that payments for medical technologies are comparable to market rates; and (2) lobby in favor of moving ahead with the Centers for Medicare & Medicaid Services' plans for a competitive bidding process for home medical equipment and encourage CMS to take into consideration quality and patient convenience, in addition to cost. (Res. 814, I-08)

D-330.923 Medicare Advantage Plans

Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates. (Res. 837, I-08)

D-330.924 Reform the Medicare System

Our AMA will renew its commitment for total reform of the current Medicare system by making it a high priority on the AMA legislative agenda beginning in 2009 and the AMA's reform efforts will be centered on our long-standing policy of pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), defined contribution (D-330.937), and balance billing (D-380.996, H-385.991, D-390.969). (Res. 834, I-08)

D-330.925 Medicare Enrollment and Re-enrollment Delays

Our AMA will seek legislation mandating that the Centers for Medicare and Medicaid Services impose a requirement on its carriers and Medicare administrative contractors (MACs) that enrollment and re-enrollment applications must be processed within thirty days of receipt with appropriate feedback to the applicant, and that financial penalties be imposed on carriers and MACs for unjustified delays in enrollment and re-enrollment. (Res. 205, I-08)

D-330.926 Herpes Zoster Vaccines and Medicare Payment for the Vaccine and for Physician Administration of the Vaccine

Our AMA will lobby for Medicare to pay for both the cost of the Herpes Zoster vaccine and the cost of administration by physicians of all vaccines covered by Medicare. (Res. 240, A-08)

D-330.927 Medicare Advantage Program Budget Reduction

Our AMA will express our grave concerns to President Bush, the Executive Branch and Congress that a veto of legislation concerning a budget reduction in the Medicare Advantage Program with a corresponding increase in the Medicare Physician Fee Schedule would be an egregious error. (Res. 236, A-08)

D-330.928 Strategies to Strengthen the Medicare Program

Our AMA: (1) will continue to study combining Parts A and B of the Medicare Trust Funds into a single program, and report back, clearly delineating the advantages and disadvantages of this action, including the effect on graduate medical education funding and of adding a means test to Medicare Part A; and (2) encourages the Centers for Medicare and Medicaid Services to explore the use of value-based, targeted benefit design to facilitate a more efficient and meaningful cost-sharing structure that will help align incentives for patients to seek appropriate and effective care. (CMS Rep. 6, I-07)

D-330.929 Medicare Abdominal Aortic Aneurysm Screening

Our AMA will work with the United States Congress to extend coverage for one time abdominal aortic aneurysm (AAA) screening to all Medicare beneficiaries age 65 to 75 who have a family history of AAA or who manifest risk factors as determined by US Preventive Services Task Force. (Res. 709, I-07)

D-330.930 Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans

Our AMA will (1) investigate, and report to the Centers for Medicare and Medicaid Services, any insurers claiming to have "deemed" panels of physicians who have agreed to accept Medicare Advantage private fee-for-service (PFFS) plan enrollees; (2) continue its efforts to educate physicians and the general public on the implications of participating in PFFS plans and other programs offered under Medicare Advantage; and (3) educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees. (BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08)

D-330.931 Adequate Formularies for Dual Eligible Patients Under Medicare Part D

Our AMA will: (1) continue working through our AMA-convened Part D Implementation Workgroup to identify Part D problems and advocate that the Centers for Medicare and Medicaid Services and the Medicare prescription drug plans (PDPs) address them; (2) survey state medical associations regarding problems that Medicare/Medicaid dual eligibles are having with the PDPs in their states and mechanisms for effectively resolving them; and (3) monitor opportunities to provide input into Medicare Payment Advisory Commission recommendations and proposed regulations, guidance and legislation that will address problems in Medicare Part D. (BOT Action in response to referred for decision Res. 710, I-06)

D-330.932 Medicare National Health Care Information Center Electronic Reform

Our AMA will urge Medicare to pursue an initiative in paper waste reduction, mandating improved efficiency by Medicare carriers to allow electronic submission of all forms, and timely electronic response relating to physician administrative issues including new applications, requests for change of address, or any other request by physicians to change provider information or status. (Res. 733, A-07)

D-330.933 Restoring High Quality Care to the Medicare Part D Prescription Drug Program

Our AMA will:

a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;

b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;

c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;

d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and

e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial. (Res. 106, A-07; Reaffirmation A-08)

D-330.934 Informed Consent and Interpretive Guidelines

Our AMA will continue to work with other organizations such as ACS, AAMC, and AHA to draft a completely revised set of acceptable informed consent Guidelines to give to CMS to replace those currently in place; and our AMA will also request that CMS immediately withdraw those portions of the Interpretive Guidelines that are most burdensome and unworkable for physicians. (BOT Action in response to referred for decision Res. 118, A-06)

D-330.935 Promoting the Utilization of New and Old Medicare Preventive Services Benefits

Our AMA will:
(1) collaborate with relevant stakeholders, including appropriate medical specialty societies, state and county medical societies, relevant federal agencies, the Partnership for Prevention, and other interested parties to actively promote to the public and the

profession the value of the Welcome to Medicare Visit, the Tobacco Cessation Benefit, and other Medicare-covered preventive services;
(2) in these collaborative efforts, emphasize reaching underserved populations, including those individuals who have had limited or no health insurance prior to reaching Medicare age;
(3) in partnership with other stakeholders, encourage the development and dissemination of educational resources to assist physicians in incorporating evidence-based preventive measures into their daily practice and in efficiently implementing the Welcome to Medicare Visit, the Tobacco Cessation Benefit, and other Medicare preventive services as part of an overall prevention approach;
(4) work with the American College of Preventive Medicine, the American Academy of Family Physicians, the American College of Physicians, the American Geriatrics Society and other interested specialty societies to seek replacement of the Medicare G-codes for tobacco cessation counseling with CPT codes, as well as their appropriate valuation through the RUC process;
(5) support the expansion of an evidence-based Welcome to Medicare Visit benefit to cover anytime within the first year of enrollment in Medicare Part B and to provide first-dollar coverage of the preventive visit and required tests (i.e., no requirement for prior deductible or co-payments); and
(6) work with the Centers for Medicare and Medicaid Services and interested medical societies to create a process involving not-for-profit voluntary health organizations (e.g., the American Cancer Society, the American Heart Association and the American Diabetes Association) to address the physician barriers to use of the Welcome to Medicare Visit, including the appropriate use of evidence-based preventive services. (BOT Rep. 8, I-06)

D-330.936 Precertification for FDA-Approved Prescription Medications

Our AMA will work to review and simplify the precertification and appeal process of Food and Drug Administration-approved prescription medications by any Medicare Part D prescription drug plans and other insurance companies. (Sub. Res. 116, A-06)

D-330.937 Make Medicare a Defined Contribution Open Economic System

Our AMA will (1) continue to support reform of Medicare by moving to a defined contribution approach that returns last dollar responsibility and control to patients; and (2) will develop its plan of action with a report back at the 2006 Interim Meeting. (Res. 112, A-06)

D-330.938 Advance Health Care Directives to Medicare Enrollees

Our AMA will 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. (Res. 8, A-06)

D-330.939 Medicare Cross-Over Claims

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to determine whether they have the authority to mandate that supplemental payers supply Medicare with monthly updates to their beneficiary eligibility data. If CMS has this authority, the AMA will lobby CMS to mandate that the secondary insurer provide monthly eligibility update to the Coordination of Benefits Contractor. If CMS does not have the authority, the AMA will lobby Congress to grant CMS this authority. (BOT Action in response to referred for decision Res. 106, A-05)

D-330.940 Power Wheelchairs and Scooters Insurance and Medicare Policies

Our AMA will:

(1) Support a revision of the Centers for Medicare and Medicaid Services (CMS) definition of medical necessity for power wheelchairs. Currently, the medical necessity definition is "bed or chair confined," which should be changed to one based on functionality as recommended by the American Academy of Physical Medicine and Rehabilitation (AAPM&R): "An individual is considered functionally ‘bed or chair confined’ if he or she is unable to walk (even with the aid of appropriate assistive devices such as prostheses, orthoses, canes, or walkers), sufficiently, to carry out the necessary mobility related activities of daily living on a daily basis. This inability may be caused by one or more medical conditions impairing strength, endurance, coordination, speed of execution, or joint range of motion sufficiently to prohibit practical ambulation."

(2) Review and present comments on the soon-to-be-published CMS Draft Guidance on power-operated wheelchairs and scooters. The Draft Guidance is scheduled to be published in October 2004, for public comment, with final regulations completed by the end of 2004.

(3) Support the efforts of the AAPM&R, American Academy of Neurology, and the 70 other organizations in the ITEM (Independence Through Enhancement of Medicare and Medicaid) coalition to change the "in the home" coverage restrictions for wheelchairs. The "in the home" language appears to be in conflict with a series of federal statutes aimed at preventing discrimination against persons with disabilities (Rehabilitation Act of 1973, Americans with Disabilities Act of 1990) and the US Supreme Court

decision in *Olmstead v. L.C. ex rel. Zimring*. (BOT Action in response to referred for decision Res. 123, A-04)

D-330.941 Medicare Outpatient Therapy Caps

Our AMA will not support H.R. 1125/S. 569, the "Medicare Access to Rehabilitation Services Act of 2003." (BOT Action in response to referred for decision Res. 127, A-03)

D-330.942 Coverage of Benzodiazepines and Substance Use Disorder Medications in the Medicare Part D Benefit

Our AMA will support legislation and urge the Secretary of the Department of Health and Human Services to exercise administrative discretion to modify or eliminate the exclusion of various prescription drugs from coverage under Medicare Part D and ensure that CMS Medicare contractors that will administer the new Medicare Part D drug benefit, known as "prescription drug plans," include on their formularies for all clinically appropriate conditions including psychiatric and substance use disorder conditions, benzodiazepines, methadone, buprenorphine, acamprosate, disulfiram, and naltrexone, so that patients will have access to these critical medications. (Res. 717, I-05; Reaffirmation A-06)

D-330.943 Physician Input in MAC Contracting Process

Our AMA will work with other interested members of the Federation to develop mechanisms with the Centers for Medicare and Medicaid Services that meaningful input from physicians and physician associations may be received and appropriately considered in the Medicare Administrative Contractor contracting processes, both those now underway and those in the future, including input on specific potential contract bidders. (Res. 714, I-05)

D-330.944 Admission Criteria for Inpatient Rehabilitation Services

Our AMA will seek a legislative change to the admission criteria for Inpatient Rehabilitation Facilities to diagnosis-specific, functional-level and limitations of the individual patient as opposed to diagnosis-specific criteria alone. (Res. 710, I-05)

D-330.945 Benzodiazepine Restrictions

Our AMA will work to end the exclusion of medications of the benzodiazepine class from CMS reimbursement. (Sub. Res. 213, A-05)

D-330.946 Provider Education

Our AMA will (1) oppose any Centers for Medicare and Medicaid Services proposal for its contractors to charge for any workshops and seminars regarding Medicare policies; and (2) work with CMS and Congress to see that proper funds are appropriated for this much-needed education. (Res. 115, A-05)

D-330.947 Educational Materials for Physicians on Medicare Part D

Our AMA will (1) prepare a report on available educational programs for physicians on Medicare Part D issues, and (2) make available appropriate educational materials targeted for physicians on Medicare Part D issues, so that they may best assist patients and effectively meet their responsibilities, under Medicare Part D laws and regulations. (Res. 105, A-05; Reaffirmation A-06)

D-330.948 Medicare Demonstration Projects

Our AMA will:

(1) encourage CMS to continue to seek input at the earliest possible occurrence from medical associations in the development of Medicare demonstration projects that are intended to contain costs and/or improve the appropriateness or quality of patient care;

(2) encourage CMS to continue to vary the types of physician practices (e.g., by size, geographic location) that it utilizes in its Medicare demonstration projects;

(3) encourage CMS to limit requirements that may make participation in Medicare demonstration projects financially and/or administratively impracticable for a wide range of physician practices; and

(4) join state and specialty societies early on to assist with developing Medicare demonstration projects to protect the interests of patients and physicians. (CMS Rep. 3, A-05)

D-330.949 Opposition to CMS Elimination of ACS Payments

Our AMA will: (1) work with national medical specialty organizations to analyze the impact of CMS' proposal to eliminate payment to ambulatory surgery centers for 100 CPT procedures; (2) assume a leadership role with other organizations (e.g., AARP) to educate patients of the negative impact of these changes; and (3) advocate against such changes using all reasonable means. (Res. 837, I-04)

D-330.950 Support for Coverage of the Consultation by a Physician Prior to Screening Colonoscopy

Our AMA will support coverage under Medicare benefits for the consultation in advance of the procedure by a physician to evaluate the patient and discuss the need for screening, risks and benefits and preparation for colonoscopy. (Res. 721, I-04)

D-330.951 Medicare Cost-Sharing

Our AMA will urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services. (CMS Rep. 2, I-04; Reaffirmation A-08)

D-330.952 Status Report on Medicare Review Activities

Our AMA will:

(1) closely monitor the Centers for Medicare and Medicaid Services' (CMS) transition to the use of Medicare Administrative Contractors to ensure physician access to local-level carrier medical directors, that contractor services are provided in an accurate and timely manner, and that these issues are considered in contracting in addition to purely financial issues;

(2) continue to advocate that CMS compensate physicians who experience significant delays in the Medicare enrollment and/or re-enrollment processes;

(3) urge CMS to increase its efforts to ensure that physicians have the option of completing the entire Medicare enrollment and/or re-enrollment processes (including the eventual application for the National Provider Identifier) electronically;

(4) urge CMS to conduct pilot tests to ensure that the electronic enrollment and re-enrollment processes will accommodate the timely processing of physician applications; and

(5) urge CMS to reduce the carrier/contractor standard for enrollment and/or re-enrollment processing from 90% in 60 days and 99% in 120 days, to 90% in 30 days and 99% in 60 days. (CMS Rep. 6, I-04)

D-330.953 Affordability of the Medicare Prescription Drug Programs

Our AMA will refer to the appropriate Council: (1) the issue of exploring reasonable mechanisms for medications to be safely re-imported, under Food and Drug Administration guidance, from other countries and report its results back to the House of Delegates at the 2004 Interim Meeting; (2) the issue of allowing Medicare to collectively negotiate drug prices with the pharmaceutical industry, as one large entity; and report back to the House of Delegates at the 2004 Interim Meeting; (3) the idea of individual states being allowed to collectively negotiate drug prices with the pharmaceutical industry, and report back to the House of Delegates at the 2004 Interim Meeting; and (4) other mechanisms to bring down the price of prescription drugs in the United States, as well as other possible federal price control mechanisms, and report back to the House of Delegates at the 2004 Interim Meeting. (Res. 212, A-04)

D-330.954 Prescription Drug Prices and Medicare

Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. (Res. 211, A-04; Reaffirmation I-04)

D-330.955 Division of Medicare into a Program for Elderly and a Program for the Disabled

Our AMA will (1) refer to the appropriate Council the issue of dividing Medicare into two programs--one for seniors and one for the disabled--which will allow a more appropriate analysis of budgetary, policy, and strategic planning of the two programs; and (2) report its results back to the House of Delegates at the 2005 Annual Meeting. (Res. 122, A-04)

D-330.956 Medicare Provider Enrollment System (PECOS)

Our AMA will advocate that the CMS:

(1) find an immediate solution to the Provider Enrollment Chain and Ownership System problems, so that enrollment applications are processed in a timely manner, and provide a definitive date when this backlog of applications will be resolved;
(2) assure interest penalties be paid to providers, who have been unable to bill for extended periods of time;
(3) establish a process whereby, upon request, the carrier is authorized to advance funds to physicians who do not yet have their enrollment number due to the enrollment backlog;
(4) not proceed with the National Provider Identifier initiative until such time as providers are assured that prepayment will be provided for all delayed processing of enrollment; and
(5) determine how the enrollment/PECOS delay may be impacting the submission of HIPAA compliant electronic claims. (Res. 132, A-04)

D-330.957 AMA Support for Revision of the CMS 75% Rule - Rehabilitation Classification Criteria

Our AMA will: (1) in its lobbying efforts, work to ensure continued access to medically necessary and appropriate inpatient rehabilitation services for all Medicare beneficiaries;
(2) support the establishment of a panel of expert rehabilitation professionals to establish new criteria such as the inpatient rehabilitation facilities – prospective payments systems (IRF-PPS) categories;
(3) actively oppose further implementation of rule 42 CFR Part 412 or any similar rule in a manner that would seriously decrease the availability of medically necessary rehabilitation services causing irreparable harm to many Medicare beneficiaries;
(4) request that Congress freeze the 75% Rule criterion at the 60% level; provide a moratorium on new Medicare rehabilitation programs; and freeze enforcement of the 75% rule for non-compliant facilities until a better regulation is created by CMS in consultation with a national commission of clinical experts; and while research on medical rehabilitation in IRFs is and other post-acute settings is complete;
(5) request that Congress, for cost reporting periods beginning on or after July 1, 2008, to include patients with comorbidity in the inpatient population that counts towards such 60% compliance rate;
(6) request that the Centers for Medicare and Medicaid Services and Medicare fiscal intermediaries, Medicare administrative contractors, recovery audit contractors, and other government agents use and apply the criteria established in HCFA Ruling 85-2, as issued on July 31, 1985, as the sole standard for determining the medical necessity of services provided by inpatient rehabilitation hospitals and units to Medicare beneficiaries; and
(7) advocate for immediate withdrawal by Medicare fiscal intermediaries of their current and proposed inpatient rehabilitation local medical review policies and discontinue further action in this regard until an independent panel of national clinical experts on inpatient rehabilitative care is convened and fully examines the issues associated with medical necessity criteria. (Res. 719, I-03; Modified: Res. 134, A-07)

D-330.958 Social Security Disability Medical Benefits

Our AMA will take an active role in supporting reduction of the waiting period to receive Social Security Disability medical benefits. (Res. 712, I-03)

D-330.959 Eligibility Age for Medicare Patients

Our AMA will evaluate implications of any incremental changes to the Medicare eligibility age for the purpose of cost savings. This evaluation should consider the impact that these changes may have on vulnerable populations with severe health disparities and lower-than average life expectancy. (Sub. Res. 711, I-03)

D-330.960 Cuts in Medicare Outpatient Infusion Services

1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.

2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents. (Res. 926, I-03; Reaffirmed and Modified: CMS Rep. 3, I-08)

D-330.961 Social Security Disability Medical Benefits

Our AMA will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients, and will report and recommend further action to the House of Delegates as appropriate. (Sub. Res. 101, A-03)

D-330.962 Revision of Medicare's Proposed Physician Enrollment Policy

Our AMA will work to simplify and reduce the difficulty and burden of the Centers for Medicare and Medicaid Services' newly

proposed Medicare Provider Enrollment Policy. (Res. 131, A-03)

D-330.963 Consolidated Home Health Care Payments by Medicare

Our AMA will alert relevant national medical specialty societies and state medical associations to Medicare policy instructing carriers to pay physicians for therapy services they render to home health patients and to exclude such payments from the Medicare consolidated home health billing protocol. (CMS Rep. 4, A-03)

D-330.964 Update to Ambulatory Surgery Procedure List

Our American Medical Association urge the Centers for Medicare and Medicaid Services to immediately update the ambulatory surgery center list of covered procedures. (Res. 706, I-02; Reaffirmation A-04; Reaffirmation I-04)

D-330.965 Rescinding Provisions Requiring Physicians to Have Hospital Admitting Privileges

Our AMA shall encourage physicians for whom Medicare+Choice and other health plans require admitting privileges for participation to alert the AMA via the AMA Health Plan Complaint Form, available at www.ama-assn.org/go/psa. (BOT Rep. 7, A-02; Reaffirmation A-04)

D-330.966 Medicare Program Safeguard Contractors

Our AMA, consistent with the principles set forth in its September 2001 letter to the Centers for Medicare and Medicaid Services, shall continue to press for legislative and/or administrative relief from the creation of Program Safeguard Contractors and other abusive contracting authority by CMS. (Res. 709, A-02)

D-330.967 Medicare Payment for Preventive Examinations

Our AMA shall: (1) continue to disseminate evidence-based recommendations regarding the appropriate use of clinical preventive services to physicians, the general public and policy makers;

(2) continue to collaborate with national medical specialty societies and interest groups to facilitate implementation of these recommendations by practicing physicians;

(3) urge Congress and the Administration to provide coverage for these clinical preventive services by the Medicare program;

(4) advocate especially for the provision of these services to populations at high risk for a given condition under guidelines available on the AMA website; and

(5) pursue the provision of preventive services with the intent of also pursuing additional funding added to the Medicare program without any reduction in reimbursement for other physician services or Medicare updates. (BOT Rep. 26, A-02)

D-330.968 Payment Adjustments for Government Programs

Our AMA shall advocate that these COLA and other increases be passed directly to physicians (see H-330.992). (Res. 113, A-02)

D-330.969 Opposition to Mandatory Hospitalization Prior to Nursing Home Placement

Our AMA shall inform the Centers for Medicare and Medicaid Services that the regulation concerning mandatory hospitalization prior to skilled nursing home placement for Medicare beneficiaries is obsolete, wasteful of valuable resources and should be abolished. (Res. 139, A-02)

D-330.970 Benefits Improvement and Protection Act 2000 Medicare Coverage

Our AMA shall advocate for implementation of the federal Benefits Improvement and Protection Act 2000 (BIPA 2000) per Congressional intent, supporting coverage based solely on the beneficiaries experience with self-administration and not the availability, ability, or willingness of other family members or caregivers in the beneficiary's home to administer an injection, as deemed appropriate by the physician. (Res. 102, A-02)

D-330.971 Medicare Preoperative Medical Evaluation

Our AMA will: (1) work with the Centers for Medicare & Medicaid Services to develop a national coverage policy on preoperative medical evaluations; and (2) report back to the House of Delegates on its progress at the 2001 Annual Meeting. (CMS Rep. 8, A-00)

D-330.972 Movement of Services from Medicare Part A to Medicare Part B without Commensurate Movement of Resources

Our AMA shall vigorously advocate for appropriate shifts of funds from Medicare Part A to Medicare Part B to finance medical services assigned to Part B in response to more efficient methods of delivery of such services. (Res. 120, A-02)

D-330.973 Requirement for Physicians to Sign Written Requests for Diagnostic Tests

Our AMA will work with the Centers for Medicare and Medicaid Services to publish instructions to Medicare contractors that clarify that the signature of the ordering physician is not required on a clinical diagnostic test order, if the order is documented in the medical record. (Sub. Res. 114, I-01)

D-330.974 Support for Maintaining the Medicare Carrier Advisory Committee and Carrier Medical Director

Our AMA will: (1) continue its efforts in urging the Centers for Medicare and Medicaid Services (CMS) management to retain and support local Medicare Carrier Advisory Committees and Medical Directors in their role as policy advisers; and (2) urge the CMS to seek input from the AMA and all interested medical societies before proposing any further changes to the Medicare Carrier Advisory Committee (CAC) framework or to the roles and responsibilities of carrier medical directors. (Res. 121, I-01)

D-330.975 CMS Proposal for Changing the Number and Responsibilities of Medicare Contractors

Our AMA will request that the Centers for Medicare and Medicaid Services do an impact analysis prior to changing the number and responsibilities of Medicare contractors through the segregation of claims processing services. (Res. 117, I-01)

D-330.976 Rescinding Provisions Requiring Physicians to Have Hospital Admitting Privileges

If necessary, our AMA will work with the Centers for Medicare and Medicaid Services to rescind the Medicare+Choice provision that requires physicians to have admitting privileges (i.e. medical staff membership) on a hospital medical staff. (Res. 716, A-01)

D-330.977 Medicare Payment for Preventive Examinations

Our AMA: (1) will make payment for preventive services a legislative priority in the coming year, and lobby or pursue other legislative efforts to include preventive examinations as a covered service; and (2) BOTwill report back at the 2002 Annual Meeting on its efforts to secure payment for preventive services (Res. 218, A-01)

D-330.978 Timely Medicare Benefits for Social Security Disability Recipients

Our AMA will study and report back by A-2002 the requirement of Medicare coverage for the disabled to start simultaneously with determination of disability by the Social Security Administration in the context of broader health system reform. (Sub. Res. 205, A-01)

D-330.979 Medicare Reimbursement for Vitamin D Therapy for Dialysis Patients

Our AMA will petition the Centers for Medicare and Medicaid Services and/or lobby Congress to defeat the "Vitamin D Analogs Draft Local Medical Review Policy" and to prevent its implementation in Florida or any other state. (Res. 134, A-01)

D-330.980 Use of "Medicare" Title

Our AMA will: (1) work with the appropriate government agencies and organizations to insure proper Medicare insurance information is disseminated to patients enabling them to make an informed decision regarding their supplemental health care coverage; including the fact that former Medicare + Choice enrollees are not guaranteed Medigap coverage; and (2) bring a report back to the House of Delegates at the 2001 Interim Meeting on action taken on this matter. (Res. 101, A-01)

D-330.981 Aspen-CMS E&M Code Vignette Project

(1) Our AMA will continue to closely monitor the development of clinical examples as a method of CMS's documentation guidelines and to ensure that the study design is appropriate;
(2) Our AMA will ensure that the development process of the proposed clinical vignettes include full and fair evaluation, by the appropriate specialty societies;
(3) The current 20 specialty societies participating in the review of the clinical examples be expanded to include more specialties, and
(4) Our AMA will ensure that the pilot studies or field testing of the clinical examples will in fact, go forward. (Sub. Res. 821, I-00)

D-330.982 Education Of Physicians About CMS Documentation Pilot Studies

(1)) Our AMA will immediately undertake an aggressive campaign to educate physicians as to the legal risk of participating in pilot studies of CMS's 2000 E&M Guidelines that do not grant them immunity from prosecution. (2) The Board of Trustees' Ad Hoc Task Force on E&M Documentation continue to function at least until A-2002. (Sub. Res. 815, I-00)

D-330.983 Appropriate Use of CMS Medicare Quality Indicators

Our AMA will: (1) support the use of CMS's Medicare quality indicators as they are currently used by peer review organizations to assist physicians in voluntarily evaluating and improving the quality of care; and (2) oppose CMS's Medicare quality indicators being used as a measure of individual physician performance, group practice performance, hospital staff performance or as a measure of medical errors. (Sub. Res. 817, I-00)

D-330.984 CMS Intrusion in Anesthesia Post-Operative Care

Our AMA will work with the CMS to modify Section 482.52 (b)(3) of the Medicare Conditions of Participation for Hospitals to allow designated physician members of the anesthesia practice or team to fulfill the post-operative follow-up requirements. (Res. 822. I-00)

D-330.985 Recognition of Medicare HMO Patients

Our AMA will ask CMS to develop a mechanism, such as a toll-free telephone number physicians can call, to assure that when patients leave traditional Medicare for a Medicare HMO, the patient's treating physicians and other providers can verify any change in that patient's insurance status. (Sub. Res. 121, I-00)

D-330.986 Private Contracting Under Medicare

Our AMA will actively lobby Congress for the passage of: "The Senior's Health Care Freedom Act" (HR 2867) as introduced by Representative Patrick Toomey (R-PA). (Res. 245, A-00; Reaffirmation A-04; Reaffirmation A-08)

D-330.987 CMS Required Diabetic Supply Forms

Our AMA, in conjunction with relevant specialty societies, will work with CMS to develop a standardized form to be used by suppliers for patients seeking reimbursement for diabetic supplies. (Sub. Res. 102, A-00)

D-330.988 Timely Processing of Medicare ID Number Applications

Our AMA will: (1) educate all physicians that CMS considers it fraud to submit Medicare claims for newer partners using another's Medicare provider number; and (2) work with CMS and Medicare carriers to simplify the process of obtaining Medicare provider numbers, to expedite the processing of applications for provider numbers, and to provide a temporary Medicare provider number until a permanent number is assigned. (Res. 131, A-00)

D-330.989 Medicare Coverage for Low Molecular Weight Heparin

Our AMA will call upon CMS to reimburse patients for the outpatient cost of low molecular weight heparin for patients diagnosed with deep vein thrombosis who meet criteria for safe management of the DVT at home. (Res. 116, A-00)

D-330.991 Medicare Carrier Advisory Committee

Our AMA will take whatever action is necessary to modify any CMS directive that would open Medicare Carrier Advisory Committee meetings to non-physicians. (Res. 122, I-99)

D-330.992 Appropriate Medical Coverage for Medicare Beneficiaries

Our AMA will: (1) continue to work with state, county, and specialty medical societies to determine the impact of plan withdrawals on Medicare patients; (2) monitor the development of legislation and regulations that would protect beneficiaries whose plans withdraw and advocate for appropriate legislation and regulations that would guarantee appropriate beneficiary protections; and (3) continue to promote adequate network standards to CMS. (BOT Rep. 16, A-99)

D-330.993 Explanation of Public-Private Partnerships that Exist between Government and the AMA

Our AMA: (1) continues to employ a variety of tactics to advocate CMS adoption of AMA policy positions;
(2) continues to work cooperatively with CMS, when possible, to achieve its policy objectives;

(3) when advocacy efforts directed at CMS fall short of achieving AMA policy objectives, the AMA continue to seek congressional action, including oversight hearings and enactment of legislation; and
(4) use appropriate legal means, including suing CMS, when appropriate and warranted. (BOT Rep. 17, A-99)

D-330.994 Study of Medicare Cost

Our AMA will seek to obtain information and develop a report of total Medicare expenditures with a breakdown of total dollars as well as percent of such following areas: physician fees, hospital fees, durable equipment, home health, administration (with specific emphasis on administrative costs relative to pursuit/collection of fraud and abuse), and other areas as deemed necessary. (Res. 138, A-99)

D-330.995 Reimbursement for Medically Necessary Injections

Our AMA will: (1) work with the CMS and with third party payers to streamline the process of obtaining reimbursement for medically appropriate injections given at the time of the visit; and (2) advocate that physicians be informed of the mechanism that CMS has to resolve in reimbursement disputes through the CMS Fair Hearing Process. (Res. 107, A-99)

D-330.996 Support for an Open Medicare Coverage Process

Our AMA will: (1) ensure that Medicare coverage is based on the current standard of care; (2) commend the CMS on the opening up of its coverage process as described in its proposed Medicare Coverage Advisory Committee process; and (3) ensure that appropriate physician input is obtained by CMS so that Medicare beneficiaries have access to the same level of care afforded to patients outside the Medicare program. (Res. 134, A-99)

D-330.997 Appropriate Payment Level Differences by Place and Type of Service

Our AMA encourages CMS to: (1) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (2) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. (CMS Rep. 7, A-99; Reaffirmation I-03)

D-335.000 Medicare: Carrier Review

D-335.984 Medicare Part B Contractor Changes

1. Our AMA will: (a) register a formal public complaint to the Centers for Medicare & Medicaid Services (CMS) about the need to accept physician input as part of future contract decisions; (b) ask CMS to require that the local Medicare Administrative Contractor and clearinghouse quickly rectify problems, including having more prompt and effective communication with providers; and (c) advocate for legislation or agency policy changes that provide additional resources to be allocated to the Centers for Medicare and Medicaid Services for the specific purpose of enhancing Part B contractor customer service and accountability in billing and enrollment matters.

2. If CMS and the local Medicare Administrative Contractor and clearinghouse fail to effectively address the problems physicians are facing, our AMA will notify elected officials and the public of these failures and the need for redress. (Res. 218, I-08)

D-335.985 Carrier Advisory Committees

Our AMA will study the current function of Carrier Advisory Committees and make any relevant recommendation for change. (Res. 119, A-06)

D-335.986 Telephone Appeals and the New Medicare Appeals Process

Our AMA will: (1) urge the Centers for Medicare and Medicaid Services to rescind the present Medicare rule requiring that all first-level appeals or redetermination requests be in writing except when the physician is requesting that the claim be reopened so that a minor error or omission, made by the physician, can be corrected; and (2) advocate for an alternative rule, allowing for a telephone appeal process to correct a minor clerical error or omission, regardless of whether the error was made by the physician or the carrier. (Res. 111, A-06)

D-335.987 Erroneous Guidance by Medicare Carriers and Waiver of Audit and Refund Penalties

1. Our AMA will: (a) ask the Centers for Medicare and Medicaid Services to enforce the requirement that Medicare representatives

who have given verbal guidance must immediately confirm that guidance in writing, requiring Medicare carriers to (i) closely monitor carrier representatives' compliance with the rule and (ii) penalize those representatives who do not comply; and (b) urge CMS to eliminate the rule that if a physician incurs a penalty having relied on erroneous guidance from a carrier representative, that penalty cannot be waived unless the physician's initial request was in writing.

2. Whether or not CMS eliminates that rule, our AMA will ask CMS to require Medicare carriers to provide central e-mail and fax units, to which physicians can send all requests for coding and billing clarifications, and from which physicians can receive all carrier responses in "real time." (Res. 110, A-06)

D-335.988 Audit Equity

Our AMA will seek relief from insurance inequity through legislation which instructs insurers to balance or refund for under-coding against any discovered over-coding during the course of an audit and not through extrapolation. (Res. 817, I-03; Reaffirmation A-08)

D-335.989 Elimination of Charges by CMS for Duplicate Claims

Our AMA will seek and/or support legislation or regulation to prohibit the Centers for Medicare and Medicaid Services from charging physicians for duplicate claims. (Res. 716, I-03)

D-335.990 Restructuring Medicare in the Short Term

Our AMA will continue its strong support and advocacy efforts towards passage of a regulatory relief bill for physicians that will provide better education for physicians on the complexities of Medicare billing and will restore fairness to the Medicare audit process. (CMS Rep. 9, A-03)

D-335.991 Medicare Review Activities

The AMA: (1) strongly urge the Centers for Medicare and Medicaid Services to ensure that each state continues to have the benefit of an exclusive, full-time medical director; and (2) urge the Centers for Medicare and Medicaid Services that adequate and reliable funding for physician education and training be provided on an ongoing basis and that such funding should not be used for other Medicare purposes. (CMS Rep. 6, I-02)

D-335.992 Medicare Carrier Medical Directors

Our American Medical Association will lobby the US Congress to pass legislation to require Medicare carriers to provide an adequate number of medical directors with adequate financial support to achieve the goals of maintaining good communications between physicians and the Medicare carriers at the local level, furthering physician education about appropriate documentation and coding and best medical practices, working to ensure timely claims adjustment, and providing accurate and timely answers to provider and beneficiary questions; and that the appropriate number of Medicare carrier medical directors in each state or region be established via joint agreements of the local carriers and the state medical societies, with a minimum number of one medical director per state unless the medical society from any given state determines that a regional multi-state medical director is adequate, and with final authority resting with the Centers for Medicare and Medicaid Services in cases where a joint agreement involving a state medical society and the local carrier cannot be reached. (Res. 714, I-02; Reaffirmation A-07)

D-335.993 Funding for the Agency for Healthcare Research and Quality

Our AMA shall send a letter to all members of the House and Senate Appropriations Committees urging support for the Agency for Healthcare Research and Quality (AHRQ) in FY2003 appropriations at the level requested by the Friends of AHRQ coalition ($390 million). (Res. 811, A-02)

D-335.994 Medical Necessity Determinations under Medicare

Our AMA will urge the Centers for Medicare and Medicaid Services and Congress that medical necessity denials within the Medicare program be reviewed by a physician of the same specialty and licensed in the same state. (Sub. Res. 713, A-01)

D-335.995 Medicare Carrier Advisory Committee Structure

Our AMA will strongly demand that the Centers for Medicare and Medicaid Services continues the regulation providing for a separate Carrier Advisory Committee for Arizona and every other state. (Res. 714, A-01)

D-335.996 Status Report on Medicare Review Activities

Our AMA will continue to monitor the Centers for Medicare & Medicaid Services's Medical Review Progressive Corrective Action approach to revising pre- and post- payment audit processes, and continue to advocate for a more defined appeals process under the program. (CMS Rep. 9, I-00)

D-335.997 E/M Documentation Guidelines: Update

Our AMA will continue to vigorously pursue resolution of unfair treatment of physicians by the Medicare program. (BOT Rep. 6, A-00)

D-335.998 Patient Safety

Our AMA will: (1) use all appropriate means to convey progress on its patient safety initiatives to the entire Federation of medicine; and (2) prepare a thorough analysis of the IOM report, its recommendations, and its implications, and report back to the Interim 2000 meeting of the House of Delegates. (Sub. Res. 202, A-00)

D-335.999 Medicare Pre-Pay Audits

Our AMA will continue to work with the Practicing Physician's Advisory Council to influence those Medicare review measures that have the potential of significant disruption and cost to physician practices. (Res. 721, A-99)

D-340.000 Medicare: PRO

D-340.996 Status Report on Medicare Review Activities

Our AMA will: (1) continue to advocate that the CMS simplify and reduce the burden that could potentially be associated with any new Medicare enrollment and validation requirements for physicians; and (2) monitor issuance of notices of final dispositions by Medicare Quality Improvement Organizations (QIOs) within the Medicare beneficiary complaint process and, as needed, work with CMS to provide further guidance to QIOs. (CMS Rep. 6, I-03)

D-340.997 Confidentiality of the Physician Peer Review Process

Our AMA will: (1) study the threat to the physician peer review process created by the U.S. District Court for the District of Columbia, July 9, 2001, ruling (Public Citizen, Inc. v. Department of Health and Human Services); (2) take urgent action, including, if necessary, introduction of federal legislation, to establish physician peer review protections of confidentiality in all federal programs and mandates, including the Emergency Medical Treatment and Active Labor Act and related regulations; and (3) consider appropriate legal or legislative action to assure that the peer review information developed by the Medicare program not be subject to disclosure or discovery. (Res. 708, I-01)

D-340.998 Peer Review Organizations

Our AMA will continue to work to reverse those portions of P.L.106-554, which remove Peer Review Organization (PRO) review of hospital issued notices of non-coverage. (Res. 702., A-01)

D-340.999 Ensuring the Accuracy of Statistics Related to Physician Billing

Our AMA will continue its efforts to discover the OIG Audit Opinion of CMS's 1997 Financial Statement and all subsequent statistics which purport to display errors in physician billing suggesting fraud and abuse (CMS Rep. 16, I-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

D-345.000 Mental Health

D-345.990 Educating Physicians and Patients About the Mental Health Parity Act

Our AMA will develop information to be posted on our AMA's Web site that would educate physicians and the public about the benefits afforded by recently passed Mental Health Parity legislation (Res. 206, I-08)

D-345.991 Access to Psychiatric Beds and Impact on Emergency Medicine

Our AMA will work with relevant stakeholders, such as the American College of Emergency Physicians, the American Psychiatric Association, the National Association of EMS Physicians, and the American Ambulance Association, to study and develop recommendations regarding the national scope of the problem of psychiatric bed availability and its impact on the nation's emergency and general medicine resources, including emergency department overcrowding. (Res. 714, A-07)

D-345.992 Promoting Parity for the Treatment of Mental Illness and Substance Use Disorders

Our AMA will work in conjunction with interested state and specialty societies to prepare a report which includes a summary and analysis of existing parity legislation and a review of the research on the impact of parity on access, quality, and the cost of health care at both the state and federal level. (Res. 910, I-06)

D-345.993 Physician Suicide

Our AMA will: (1) work with the American Foundation for Suicide Prevention and the Federation of State Physician Health Programs to study, to educate physicians, and to increase awareness through medical schools, state physician health committees, the AMA Alliance, and internal publications to anticipate, mitigate and eliminate, as far as possible, the preventable endemic catastrophe of physician suicide; and (2) contact the director of the Substance Abuse and Mental Health Services Administration and the American Psychiatric Association to join with the initiative to explore ways to act now to reduce the high prevalence of suicide in the United States particularly among physicians. (Res. 429, A-06)

D-345.994 Increasing Detection of Mental Illness and Encouraging Education

Our AMA will work with: (1) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (2) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers. (Res. 412, A-06)

D-345.995 Responding to Depression, Suicide, Substance Use, and Addiction on College Campuses

Our AMA:

(1) Council on Medical Service will evaluate health insurance coverage of full-time undergraduate and graduate students.
(2) Will recommend that any such insurance coverage should have full parity for mental health and substance abuse treatment, which is consistent with established AMA policy (H-185.974, AMA Policy Database).
(3) Will recommend that colleges and universities increase the availability and ensure the quality and quantity of on-site mental health and substance abuse clinical services and/or improve access to appropriate community services.
(4) Will advocate for the elimination of college and university policies that discriminate against students who disclose or seek treatment for depression, substance use disorders, or other mental health issues, including polices that mandate suspension or withdrawal from school for students who request or receive psychiatric or addiction medicine services.
(5) Will encourage the Association of American Medical Colleges (AAMC) to develop similar programs in medical schools.
(6) Will encourage clinical staff of campus health services and campus counseling services of colleges and universities to improve their skills in screening, brief intervention and referral for students' problem drinking.
(7) Will seek funding in cooperation with interested partners to educate physicians and the media to focus attention on the issues and linkages of substance use and addiction, mental disorders, and suicide among college students. (CSAPH Rep. 8, A-06)

D-345.996 Depression and Suicide on College Campuses

Our AMA will:
(1) work in conjunction with all appropriate specialty societies to prepare a report on depression, substance abuse, and suicide on college campuses and will include in its report a review of available scientific data on the efficacy of prevention programs aimed at reducing the incidence of depression, substance abuse, and suicide on college campuses; (2) review the existing data on access to and utilization of college mental health and substance abuse services; and (3) advocate for the development of guidelines concerning appropriate access to psychiatric, addiction medicine, and other mental health and substance abuse services on college campuses. (Res. 425, A-05)

D-345.997 Access to Mental Health Services

Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment.or mental illness; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process. (CMS Rep. 9, A-01)

D-345.998 Medicare Payment for Psychiatric Diagnoses

Our AMA, in coordination with patient and consumer groups, communicate its opposition to the 50% co-payment to CMS and to

Congress. (Res. 101, A-00)

D-345.999 Discriminatory Treatment of Psychiatric Illness and Psychiatrists by the Insurance Industry

(1) Our AMA will develop model state legislation that provides psychiatric patients with nondiscriminatory utilization review and precertification. (2) Since responsibility for U.R. and precertification policies for mental health is carved-out in many plans, the Board of Trustees is requested to ask the Council on Medical Service to revisit these and other issues of mental health carve-outs and report back with policy recommendations to the House at I-2000. (Sub. Res. 715, I-99)

D-350.000 Minorities

D-350.992 Medicaid Coverage for American Indian and Alaska Native Children

Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located. (BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07)

D-350.993 Establishing an FDA Minority Health Committee

Our AMA:

(1) and its Minority Affairs Consortium will urge the United States Congress to establish a Food and Drug Administration Minority Health Committee to address effective strategies to increase the participation of minority patients and investigators in clinical trials and medical research as one way to eliminate health disparities;

(2) through its MAC, will provide information to minority physicians on the benefits of being a clinical trial investigator;

(3) will encourage and work with the appropriate organizations to include more minorities in clinical trials and medical research as patients and investigators as one way to eliminate racial and ethnic health disparities; and

(4) will urge the US Congress and the FDA to develop an incentive program, like the Pediatric Incentive Program, that will encourage increasing the number of minorities in clinical trials and medical research. (Res. 426, A-05)

D-350.994 Continued Support for Diversity in Medical Education

Our AMA will publicly state and reaffirm its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training. (Res. 325, A-03)

D-350.995 Reducing Racial and Ethnic Disparities in Health Care

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03)

D-350.996 Strategies for Eliminating Minority Health Care Disparities

Our American Medical Association: (1) commend the Institute of Medicine (IOM) on its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," and that all applicable AMA Councils be requested to formally review the IOM report and its recommendations and submit reports back to the AMA House of Delegates at the 2003 Interim Meeting from their areas of expertise with specific strategies to move towards the elimination of racial and ethnic health care disparities; and (2) identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. (Res. 731, I-02)

D-350.997 Racial and Ethnic Disparities in Health Care

Our AMA shall create a program on health disparities using expertise in science, medical education, and ethics to: (1) work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community more aware

of health disparities and their effect on health outcomes; (2) identify and help providers implement strategies to reduce disparities in health care; (3) advocate for the appropriate role of the profession in eliminating health care disparities; and (4) work with the US Department of Health and Human Services (DHHS) under the DHHS-AMA Memorandum of Understanding supporting the goals of Healthy People 2010, including the elimination of health disparities. (CMS Rep. 1, I-02)

D-350.998 Health Initiatives on Asian-Americans and Pacific Islanders

Our AMA will expand its minority health policies to include Asian Americans and Pacific Islanders. (Res. 404, A-00)

D-350.999 Medical Education for Members in Underserved Minority Populations

In conjunction with the minority affairs consortium and other appropriate organizations, develop a plan for implementation of a national conference on access to health care in accordance with AMA policy H-160.959, and present that plan at A-2000.

D-355.000 National Practitioner Data Bank

D-355.997 Reporting of Resident Physicians

Our AMA will: (1) continue to monitor the types of information reported about resident physicians to federal and state agencies, especially the National Practitioner Data Bank and state medical licensing boards; and (2) draft and advocate for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with policy H-355.983, and oppose the expansion of existing reporting requirements. (CME Rep. 4, I-01)

D-355.998 National Practitioner Data Bank

Our AMA will: (1) work with state licensing board or other appropriate state agencies, state medical societies, specialty societies, and the Federation of State Medical Boards to develop accurate state-based physician profiling systems; and (2) support projects by state medical societies that encourage the provision by individual physicians of relevant physician-specific information. (BOT Rep. 31, I-00)

D-355.999 National Practitioner Data Bank

Our AMA will provide regular updates on the National Practitioner Data Bank to the AMA House of Delegates. (Sub. Res. 820, I-99)

D-360.000 Nurses and Nursing

D-360.994 State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification

Our AMA, through its Council on Legislation, will work expeditiously to develop and circulate to all state medical and national medical specialty societies, model state legislation that would prohibit the National Board of Medical Examiners from using the past, present or future content of its United States Medical Licensing Examination Step 3 exam, and National Board of Osteopathic Medical Examiners from using the past, present or future content of its COMLEX 3 Exam in the certification processes for non-physician providers. (Res. 212, I-08)

D-360.995 Clinical Skills For Labor and Delivery Nurses

Our AMA will encourage the National League of Nursing Accrediting Commission and the Commission on Collegiate Nursing Education to emphasize education and certificate training programs that assure the necessary clinical skills for labor and delivery nurses to be able to adjust the rate of epidural infusion for patients. (Res. 530; A-03)

D-360.996 The Effect of the Nursing Shortage on Medical Education

Our AMA: (1) shall encourage accrediting bodies for medical education programs (the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education) to rigorously enforce (or develop and enforce) standards to ensure that the educational experience of trainees is not compromised by inadequate staffing levels of nursing and ancillary personnel in teaching hospitals;

(2) using data from internal and external sources, shall monitor the national and regional availability of nursing and ancillary personnel and the mechanisms used by hospitals and other health care institutions to provide staff coverage;

(3) through the Medical Schools, Medical Student, and Resident and Fellow Sections, shall collect data on how the availability of

nursing and ancillary personnel is affecting the educational experiences of physicians-in-training;

(4) shall support increased funding for basic nursing education. This funding should come from new monies, not from funds currently devoted to medical student or resident physician education; and

(5) shall monitor efforts to increase recruitment and retention of individuals in nursing education and practice and the implications of basic nurse staffing levels on patient safety and access to care. (CMS Rep. 8, A-02)

D-360.997 The Effect of Nursing Shortage on Medical Education

Our AMA will study and report back the effects of the nursing shortage on the working environment of physicians-in-training. (Res. 309, I-01)

D-360.998 The Growing Nursing Shortage in the United States

Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;

(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;

(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;

(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;

(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care. (CMS Rep. 7, A-01; Modified: Res. 708, A-03)

D-365.000 Occupational Health
(See also: Preventive Medicine; Public Health)

D-365.997 NIOSH as an Independent Branch of HHS

Our AMA will not pursue advocacy efforts to establish the National Institute for Occupational Safety and Health as an independent agency, but will continue to support funding for the Centers for Disease Control and Prevention, so as a result NIOSH receives adequate funding. (BOT Action in response to referred for decision Res. 441, A-05)

D-365.998 Physician Guidelines for Return to Work After Injury or Illness

Our AMA will: (1) encourage members of the Federation to undertake the development of evidence-based guidelines on return to work and functional recovery that address the unique elements for their specialties or particular laws and regulations in their geographic areas; and (2) consider convening a Federation task force to evaluate the role of physicians in facilitating early return to work for patients with medically associated disability, and to provide guidance for physicians in accomplishing this task. (CSA Rep. 12, A-04)

D-365.999 Prophylaxis for Medical Students Exposed to Bloodborne Pathogens

(1) Our AMA will work with the Department of Health and Human Services to seek that references to "staff" in the proposed conditions of participation for hospitals expressly include "students and/or trainees" before they are finalized.

(2) Our AMA is unsuccessful in achieving the desired outcome in Recommendation 1, our AMA will work with OSHA to obtain a clarifying interpretation of the current OSHA requirements that would have the effect of broadening the application of their bloodborne pathogen standards to include medical students and trainees.

(3) Our AMA is unsuccessful in fulfilling Recommendation 2, our AMA will develop model legislation to establish new standards to ensure appropriate prophylaxis and counseling are made available to medical students and trainees exposed to bloodborne pathogens.

(4) Our AMA will make a concerted effort to encourage medical schools to require, as part of their affiliation agreements with medical centers, that CDC and other applicable guidelines and standards be applied also to medical students and trainees. Additionally, Our

AMA draft and disseminate model contract language for medical schools to use when contracting with hospitals. And further, Our AMA incorporate an effective enforcement mechanism into the model contract language. (BOT Rep. 21, I-00)

D-370.000 Organ Donation and Transplantation

D-370.987 Study Incentives for Cadaveric Organ Donation

Our AMA will place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of "valuable consideration" for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out. (Res. 10, A-08)

D-370.988 Hematopoietic Stem Cell Transplantation: Utilization of and Minority Representation on the National Bone Marrow Donor Registry

Our AMA will:

(1) monitor National Marrow Donor Program (NMDP) efforts to maintain a Registry that is large in number, representative of all racial and ethnic groups, and diverse in its human leukocyte antigen (HLA) types; these efforts include projects that aim to increase minority recruitment, retain existing donors, and recruit donors to replace those lost through attrition;

(2) encourage the NMDP to expand its efforts to increase utilization of the Registry through projects aimed at increasing patient and physician awareness of the NMDP, and at reducing the time and cost of stem cell procurement; and

(3) encourage the NMDP to enhance efforts to increase the number of umbilical cord blood units donated to the Registry; particular attention should be paid to increasing donation by minorities. (CSAPH Rep. 7, A-07)

D-370.989 Organ Donation Procurement

Our AMA will send a communication to the United Network for Organ Sharing (UNOS) encouraging it to convene in the next few years a series of meetings that would fulfill the intent of the resolution and offering AMA representation at such meetings. (BOT Action in response to referred for decision Res. 2, A-06)

D-370.990 Umbilical Cord Blood Transplantation: The Current Scientific Understanding

Our AMA will: (1) encourage continued research into the scientific issues surrounding the use of umbilical cord blood-derived hematopoietic stem cells for transplantation, including the ex vivo expansion of umbilical cord blood-derived hematopoietic stem cells; the combination of multiple units of closely matched, unrelated umbilical cord blood cells for transplantation; and the improvement of umbilical cord blood cells collection techniques; and

(2) work with appropriate organizations to educate physicians and the public about the potential benefits of, and limitations to, umbilical cord blood transplantation as an alternative to bone marrow transplantation. (CSA Rep. 2, A-03)

D-370.991 Shared Accountability for Increasing Organ and Tissue Donations

Our AMA will escalate efforts at the national level to broaden shared accountability for increasing organ and tissue donation through: (1) working with the American Hospital Association and the Association of Organ Procurement Organizations (AOPO) to educate physicians and hospital personnel about the Joint Commission on Accreditation of Healthcare Organizations standard regarding reporting imminent hospital deaths; (2) asking that the AMA commissioners to JCAHO request that JCAHO extend the definition of elements of performance to include failure to identify and/or refer potential organ and tissue donors in a timely manner; (3) sending a letter to the US Department of Health and Human Services Secretary supporting the AOPO's request for the Secretary's Advisory Committee on Transplantation to convene an invitational leadership conference to consider this specific proposal for shared accountability in more detail, particularly as it may relate to the nation's largest hospitals; (4) seeking support/endorsement from specialty societies, such as American College of Physicians and American College of Surgeons, for these shared accountability efforts; and (5) encouraging the Centers for Medicare and Medicaid Services to include a requirement in the Medicare Conditions of Participation regarding donation advocacy. (Res. 509, A-03)

D-370.992 Increasing Organ Donation

(1) Our AMA shall continue to promote organ donation awareness.

(2) Our AMA seek extramural funding to update the Live and Then Give program to increase physician awareness of the need for organ donation and make a Web-based version of this program available for state and specialty societies for adaptation.

(3) Our AMA seek extramural funding to convene a workshop with members of the Federation, the transplant community, and the Health Resources and Services Administration, Division of Transplantation, to develop best practices for physician participation in the organ donation process and for the medical management of potential organ donors.

(4) Our AMA reaffirm existing AMA policy regarding organ donation and reissue AMA donor cards to all AMA members and their patients to the extent permitted by and consistent with applicable laws. In addition, donor cards should be readily available on our AMA website for downloading. (CSA Rep. 4, I-02)

D-370.993 Increasing the Number of Donor Organs

Our AMA shall: (1) renew and continue to support its national organ donor awareness campaign, Live and Then Give, with a report back to this House of Delegates at its 2002 Interim Meeting on the strategies for the AMA's ongoing support to alleviate the crisis of organ donor shortage in the US; and (2) work with other appropriate organizations such as the United Network of Organ Sharing (UNOS) and the Health Research Services Administration (HRSA), on a nationwide program to educate the public on the need for organ donation. (Res. 512, A-02)

D-370.994 Safety of Tissues for Transplantation

Our AMA will: (1) support efforts to ensure that the FDA has adequate resources to carry out the oversight activities outlined in its current proposed rule; (2) continue to promote physician awareness of the need for organ and tissue donation; and (3) recognize the altruism of the donors and donors' family that makes the availability of tissues a reality for the more than 700,000 recipients of tissue allografts in the United States. (CSA Rep. 5, I-01)

D-370.995 Anatomical Gifts

Our AMA, in collaboration with state medical societies, will confer with existing state anatomical boards, medical school representatives, ethicists and other appropriate parties, in order to evaluate and, as appropriate, advocate for establishment of additional safeguards and protocols for procurement and use of cadaver organs and tissues in research and education. (BOT Rep. 5, A-01; Reaffirmation I-07)

D-370.996 Xenotransplantation: Scientific Implications

Our AMA will: (1) support the Secretary of the Department of Health and Human Services' Advisory Committee on Xenotransplantation (SACX) to encourage public discussion and education on the unique issues associated with the topic; and (2) monitor the development of guideline documents produced by the major stakeholders, and revisit the issue in the future as the research becomes more clinically relevant. (CSA Rep. 8, I-00)

D-370.997 The Physician's Role in Organ Donation

Our AMA will:(1) continue to promote organ donation awareness;

(2) encourage the Department of Health and Human Services to widely distribute the "Roles and Training for the Donation Process: A Resource Guide";

(3) work with members of the Federation, the transplant community, and the Department of Health and Human Services to convene a workshop to develop the best practices for medical management of potential organ donors, which respect honoring of advance directives by physicians;

(4) encourage physicians to be aware of the important issues involved in discussing brain death and organ donation with families, and encourage physicians to participate in training to work effectively with Organ Procurement Organization coordinators to present the option of organ donation to families; and.

(5) will work to amend CMS 42CFR482.45 to include language directing the designated organ donation requestor to contact the attending physician prior to organ donation requests, to include the attending physician in the discussion with the family if he or she desires. (CSA Rep. 6, A-00)

D-370.998 Organ Allocation

Our AMA will monitor the outcome of the proposed final rule: "Organ Procurement and Transplantation" issued by the Department of Health and Human Services and respond as appropriate. (CSA Rep. 12, I-99)

D-370.999 Xenotransplantation Clinical Trials

Our AMA in conjunction with other appropriate organizations will study the ethical and scientific implications of xenotransplantation and report on its recommendations (Res. 505, A-99)

D-373.000 Patients

D-373.999 Informed Patient Choice and Shared Decision Making

Our AMA will work with state and specialty societies and others as appropriate to educate and communicate to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care. (Res. 817, I-08)

D-375.000 Peer Review
(See Also: Managed Care; Medical Records; Medical Review; Medicare: Carrier Review)

D-375.989 Inappropriate Peer Review

Our AMA will study the issue of abuse of the peer review process. (Res. 18, A-07)

D-375.990 Legal Protections for Medical Peer Review

Our AMA will:
(1) establish a thorough definition of medical peer review as a process conducted by physicians to assure that all physicians consistently maintain optimal standards of fitness to practice medicine;
(2) on the basis of this definition of medical peer review, advocate in legislative and judicial forums for essential protections and privileges for immunity of medical peer review records and processes from discovery in litigation; and
(3) work through the Federation of State Physician Health Programs and other appropriate organizations to ensure the broadest application of medical peer review to include the evaluation of physician health and fitness to practice medicine. (Res. 914, I-06)

D-375.991 IOM Report on QIO Program

Our AMA will advocate that: (a) the medical review duties currently included in the Medicare Quality Improvement Organization (QIO) scope of work continue to remain the responsibility of the federally designated QIO in each state through the end of the current Eighth Scope of Work on into the Ninth Scope of Work and beyond; and (2) medical review of physicians continue to be performed by physicians taking into account both cultural competency and local conditions. (Res. 726, A-06)

D-375.992 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations

The AMA will:
(1) make available a document entitled "Principles for Incident-Based Peer Review" as an appendix to the next revision of the Physician's Guide to Medical Staff Organization Bylaws;

(2) develop and make available a document entitled "Principles for Incident-Based Peer Review" to all state medical societies and hospital medical staffs in the United States; and

(3) consolidate the AMA's complete peer review policies into a single policy or document that is user-friendly and available through PolicyFinder. (BOT Action in response to referred for decision BOT Rep. 23, A-05)

D-375.993 Confidentiality of Peer Review

Our American Medical Association will develop and seek federal legislation consistent with Policies H-230.957, "Access to Hospital Records," H-375.972, "Lack of Federal Peer Review Confidentiality Protection," and H-375.973, "Protecting Physicians at the Peer Review Process in the Current Managed Care Environment." (Sub. Res. 922, I-04; Reaffirmation A-05)

D-375.994 Principles for Incident-Based Peer Review

Our AMA Board of Trustees will study and report back at the 2004 Annual Meeting the advisability of adopting the Massachusetts Medical Society Model Principles for Incident-Based Physician Peer Review and Disciplining at Health Care Facilities; and our AMA will send the Model Principles to all state medical societies and all medical staffs in the US and prominently post them on the AMA's web site should they be adopted by our AMA. (Res. 835, I-03)

D-375.995 Medicare Review Activities

Our AMA immediately work with the Administration and Congress to enact legislation that is consistent with Policy H-375.972 and report back at the 2003 Interim Meeting. (CMS Rep. 6, I-02)

D-375.996 Peer Review Immunity

Our AMA: (1) recommends that medical staffs adopt bylaws that provide for a peer review process that is consistent with HCQIA criteria and AMA policy;

(2) recommends medical staffs include bylaw provisions that provide an option or alternative for external and impartial review when there is an allegation by a reviewed physician;

(3) recommends that if physicians believe that negligent or misdirected peer review is a problem, legislative action be considered at the state level to assure a fair due process proceeding for physicians subject to review;

(4) shall request that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require medical staff bylaws to include due process protections for peer review, including the option for external and impartial review; and

(5) shall continue to monitor the legal and regulatory challenges to peer review immunity and non-discoverability of peer review records and proceedings, as well as consider legislative remedies, including the feasibility and impact of amending HCQIA to provide the option for external peer review for hospital medical staff physicians. (BOT Rep. 25, A-02; Reaffirmation A-05)

D-375.997 Peer Reviewer Immunity

Our AMA will: (1)recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process and report back at Annual 2002; and (3) continue to work to provide peer review protection under federal law. (BOT Rep.8, I-01; Reaffirmation A-05)

D-375.998 Peer Review Protection for Physicians Covered by the Federal Tort Claims Act

Our AMA will work with the Indian Health Service headquarters, Public Health Service, and the Department of Health and Human Services Office of the General Counsel to enact federal legislation protecting the confidentiality of peer review/clinical quality assurance information done by physicians and organizations covered by the Federal Tort Claims Act. (Res. 230, A-01)

D-375.999 Confidentiality of Physician Peer Review

Our AMA will draft and advocate for legislation amending, as appropriate: (1) the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act; and (2) the Health Care Quality Improvement Act to prohibit discovery of information obtained in the course of peer review proceedings. (BOT Rep. 22, A-01)

D-380.000 Physician Fees

D-380.995 Support the Removal of Limiting Charges for Physicians Services Under Medicare

Our AMA will immediately call upon Congress for the removal of limiting charges for physicians' services under Medicare and preemption of state laws limiting charges for physicians' services and report on progress to the AMA House of Delegates annually, at both the annual and the interim meetings. (Res. 218, A-08)

D-380.996 Balance Billing for All Physicians

1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.

2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of

balance billing bans in insurance-physician contracts.

3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.

4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals. (Res. 925, I-07)

D-380.997 Private Contracting by Medicare Patients

(1) Our AMA reaffirm Policy H-380.989 which states that it is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry.

(2) Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.

(3) Our AMA reaffirm Policy H-165.913(2) which states that the AMA advance its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare. (CMS Rep. 6, A-99; Reaffirmation A-04; Reaffirmation A-08)

D-383.000 Physician Negotiating

D-383.983 Collective Bargaining: Antitrust Immunity

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy. (BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07)

D-383.984 ERISA and Managed Care Oversight

Our AMA will develop, propose, and actively support (1) federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; (2) federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and (3) federal and state legislation prohibiting "all products" clauses or linking participation in one product to participation in other products ("tied") administered or offered by third party payers or their affiliates. (Res. 915, I-06)

D-383.985 Fair Valuation of Physician Services in Third Party Payer Contracting with Hospitals and Health Care Systems

Our AMA will:
(1) continue to advocate for fair payment for physician services regardless of the employment status of physicians on organized medical staffs;
(2) develop a new federal antitrust legislative strategy, and reopen a dialogue with the Department of Justice and the Federal Trade Commission concerning more flexible approaches to physician network joint ventures;
(3) continue to encourage all physicians who would like to report the unfair business practices of health insurers and other payers to complete the AMA online health plan complaint form; and
(4) work to ultimately eliminate the need for cross subsidization practices between third party payers and hospital systems that result in: (a) a decrease in physician market power, (b) a devaluation of physician services, and (c) harm to competition. (BOT Rep. 13, I-06; Reaffirmation A-08)

D-383.986 Managed Care Environment

Our AMA will prepare an action plan and model legislation for states to enhance the bargaining power of physicians on behalf of their practices and their patients in this new environment, and conduct a study to determine model state laws to regulate the uneven relationship between health plans and physicians. Recommendations will be presented to the House of Delegates at the 2007 Annual

Meeting. (Res. 217, A-06)

D-383.987 State Managed Care Legislation

Our AMA will prepare and distribute to states model legislation to allow for more complete state review processes of future mergers and acquisitions of health plans. (Res. 203, A-06)

D-383.988 Collective Bargaining and the Definition of Supervisors

Our AMA will: (1) support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al*; and (2) request that the Federation of Medicine publicly support Physicians for Responsible Negotiation's (PRN) legal efforts and consider additional legal support, as amicus curiae or otherwise, in an appropriate court case that may result in the overturning of *Kentucky River*. However, this request should only be made if PRN actually has a case that may be considered a strong appeal for the purpose of overturning *Kentucky River*. (BOT Action in response to referred for decision Res. 248, A-01)

D-383.989 Physician Freedom to Collectively Negotiate with Managed Care Plans and Health Insuring Organizations

Our AMA will:

(1) increase the visibility of its campaign for antitrust relief for physicians, including specific strategies for accomplishing this goal;

(2) prepare and distribute to its membership educational materials pertaining to current antitrust issues as it affects its members;

(3) empower its members through these educational materials to embark upon a grassroots legislative campaign to secure antitrust relief for physicians when negotiating with third party payers;

(4) speak forcefully to its membership that no member should feel compelled to sign any contractual agreement that harms his/her ability to provide compassionate and quality care to his/her patients; and

(5) advance as part of its patient advocacy campaign that physicians must have the right to enter into group discussions with managed care companies, exempt from antitrust violations, for the purpose of reducing the barriers to patient access and administrative burdens on physicians that delay patient care even if prohibited, by law, from discussing fees and reimbursement rates. (Sub. Res. 229, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-08)

D-383.990 AMA's Aggressive Pursuit of Antitrust Reform

Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;

(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine";

(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;

(4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;

(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and

(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. (Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08)

D-383.991 Continued Support of Physicians for Responsible Negotiation

(1) The Board of Trustees requests from PRN a revised proposal for funding that preserves PRN's ability to bring to conclusion the currently pending litigation before the National Labor Relations Board in which PRN is a party.

(2) After review of the revised proposal submitted by PRN, the Board of Trustees shall provide sufficient funding to PRN to obtain final decisions from the National Labor Relation Board in the two appeals currently pending before it, consistent with the Board's prudent exercise of its legal and fiduciary responsibilities to the AMA. (Sub. Res. 609, A-02)

D-383.992 Cost Analysis, Campbell Bill

Our AMA will consider being one of twenty contributors of $5,000 each funding an analysis by the Law and Economics Consulting Group on the effects to consumers and employers of the Campbell Bill that was passed by the US House of Representatives and present these findings to the US Senate or House. (Res. 210, A-01)

D-383.993 Hospital-Based Physician Contracting

(1) Our AMA revise its Private Sector Advocacy information request form on the AMA web site so that physicians wanting to report unfair contract practices with hospitals are encouraged to participate in this information gathering tool. (2 Our AMA widely communicate availability of the reporting mechanisms for unfair contract practices, as well as other existing AMA contracting resources through the AMA Web site and other communication vehicles. (CMS Rep. 3, A-00)

D-383.994 AMA Becomes a Resource on How to File Class Action Suits against Managed Care Organizations for Denial and Delay of Payment of Claims

Our AMA BOT will urge the AMA/State Medical Society Litigation Center to become a resource for assisting state and local medical societies on how to file a class action suits against managed care organizations. (Res. 704, A-00)

D-383.995 Increase Funding for PRN

Our AMA will consider whatever is legally possible and fiscally responsible to support the continued viability of Physicians for Responsible Negotiation (PRN). (Sub. Res. 616, A-00)

D-383.996 Impact of the NLRB Ruling in the Boston Medical Center Case

Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations. (CME Rep. 7, A-00)

D-383.997 Educating the American Public about Physicians for Responsible Negotiation (PRN)

Our AMA will educate physicians and the American public regarding the benefits and advantages to be derived on their behalf from activities of Physicians for Responsible Negotiation (PRN). (Sub. Res. 718, I-99)

D-383.998 Impact of the NLRB Ruling in the Boston Medical Center Case

Our AMA will prepare a report on the potential impact of the National Labor Relations Board ruling on physicians-in-training, including issues related to education, GME funding, resident finances and the formation of housestaff organizations. (Res. 309, I-99)

D-383.999 Alternative to the Development of a Collective Bargaining Unit for Resident Physicians

(1) Our AMA support and reinforce mechanisms within the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) to address and resolve resident issues at the program and institutional levels. (2) Policy H-310.933, calling for the AMA to assist in the development of independent (professional) housestaff organizations, be reaffirmed. Further, the AMA should encourage the ACGME immediately to convene a task force drawn from its sponsoring organizations to develop a model for a professional housestaff organization that can serve as a vehicle to address and resolve conflicts between housestaff and sponsoring institutions. (3) Our AMA immediately develop and implement mechanisms to provide direct assistance to individual residents and groups of residents with work-related concerns, such as the creation of a housestaff support unit coordinated by the AMA, and identify the costs of implementation of such a plan. Such a unit should be structured to confidentially address resident issues and conflicts at the program or institution levels and diminish the need for intervention by the ACGME. (Res. 914, A-99)

D-385.000 Physician Payment

D-385.968 Support for Appropriate Billing and Payment Procedures by Physicians

Our AMA will oppose any attempts by federal and state legislatures, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for procedures and services based on physician specialty. (BOT Rep. 32, A-08)

D-385.969 FDA Regulation of Stereotactic Breast Biopsy

Our AMA will monitor the activities and recommendations of the National Mammography Quality Assurance Advisory Committee and the Food and Drug Administration pertaining to interventional mammography procedures and respond as approriate. (BOT Action in response to referred for decision Res. 513, A-07)

D-385.970 Tiering System for Third-Party Payers

Our AMA will publish a National Health Insurers Report Card (NHIRC), and include in the metrics for the NHIRC the frequency of prior authorization or precertification of services and pharmaceuticals. (BOT Rep. 11, A-08)

D-385.971 Gain-Sharing

Our AMA will conduct a study and prepare a report on gain-sharing arrangements between physicians and hospitals. (Res. 121, A-08)

D-385.972 National Provider Identification (NPI) Implementation

Our AMA will: (1) send to the Centers for Medicare and Medicaid Services and the major private sector payers a letter communicating our concerns regarding the failure to pay physicians in a timely manner due to these carriers' implementation of the National Provider Identification and ask these payers to move expeditiously to end these payment delays; and (2) bring a status report on this action at its 2008 Annual Meeting. (Res. 923, I-07)

D-385.973 ERISA Plans and the United States Department of Labor

1. Our AMA will seek federal legislation that would modify Employee Retirement Income Security Act law to incorporate a clause that addresses timely payment of medical claims of health care practitioners who provide treatment in good faith to the members of self-funded group employer-sponsored health plans.

2. When the federal law is amended, our AMA will work with the United States Department of Labor to devise and implement a formalized appeal process at the United States Department of Labor. (Res. 213, A-07)

D-385.974 Freedom of Practice in Medical Imaging

Our AMA will:

(1) encourage and support collaborative specialty development and review of any appropriateness criteria, practice guidelines, technical standards, and accreditation programs, particularly as Congress, federal agencies and third party payers consider their use as a condition of payment, and to use the AMA Code of Ethics as the guiding code of ethics in the development of such policy;

(2) actively oppose efforts by private payers, hospitals, Congress, state legislatures, and the Administration to impose policies designed to control utilization and costs of medical services unless those policies can be proven to achieve cost savings and improve quality while not curtailing appropriate growth and without compromising patient access or quality of care;

(3) actively oppose efforts to require patients to receive imaging services at imaging centers that are mandated to require specific medical specialty supervision and support patients receiving imaging services at facilities where appropriately trained medical specialists can perform and interpret imaging services regardless of medical specialty; and

(4) actively oppose any attempts by federal and state legislators, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for imaging procedures based on physician specialty, and continue to support the reimbursement of imaging procedures being performed and interpreted by physicians based on the proper indications for the procedure and the qualifications and training of the imaging specialists in that specific imaging technique regardless of their medical specialty. (Res. 228, A-05; Reaffirmed in lieu of Res. 901, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmed in lieu of Res. 125, A-07; Reaffirmation A-08; Reaffirmed: BOT Action in response to referred for decision Res. 513, A-07)

D-385.975 Balance Billing for all Payers

Our AMA will: (1) prepare legislation to allow physicians to balance bill regardless of the payer and seek sponsors for this in the US

Congress; (2) support federal and state legislation and regulation that permits physicians and hospitals to cancel or reduce copayments for hardship cases without change in fee schedules; and (3) make balance billing a high priority and report back to the House of Delegates at the 2005 Interim Meeting with a plan of action on balance billing for all payers. (Sub. Res. 113, A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06

D-385.976 Published Reimbursement Schedules by Private Insurers

Our AMA will request that all state insurance regulators require all private insurers to make available to each participating physician practice their updated payment schedules on an annual basis, and interim updates to the payment schedule should be provided to contracted physicians at least 90 days prior to the effective date. (Res. 805, I-04)

D-385.977 Reimbursement Denial Based Solely on Specialty

Our AMA will actively: (1) support appropriate actions at both the state and federal levels to ban insurers from denying or reducing payment for services performed by physicians (MD and DO) based solely on their specialty; and (2) discourage insurance companies from restricting professional fee payment to MDs and DOs based on type of specialty. (Sub. Res. 809, I-03)

D-385.978 Language Interpreters

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;

(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;

(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;

(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and

(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. (Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07)

D-385.979 Physician Reimbursement

In this time of budgetary crisis our AMA should aggressively pursue legislation and regulation to protect physician payment and thereby ensure patient access to physicians. (Res. 716, A-03)

D-385.980 Provision of Payment Schedules and Methodology of Payment as Part of the Contracting Process

State medical associations that wish to pursue a ruling for their individual members similar to that used by the Medical Association of Georgia in obtaining relief from payment contract practices which do not disclose the full term of reimbursement should contact the Litigation Center for support. Our AMA, within its resources, should continue to assist physicians and medical associations that pursue well grounded legal actions to secure disclosure from MCOs of their fee schedules and payment methodologies. (BOT Rep. 13, A-03; Reaffirmation A-08)

D-385.981 Increased Administrative Fees for Multivalent Vaccines

Our AMA: (1) advocate with the Centers for Medicare and Medicaid Services and ALL other payers to effect an increase in the administration fee for multivalent vaccines to reflect the true costs to the physician for the administration of such vaccines; and (2) work with the Centers for Medicare and Medicaid Services and appropriate specialty societies to develop pediatric specific immunization codes to accurately reflect the physician work in administering vaccines to the pediatric population. (Res. 731, I-02)

D-385.982 Tax Relief for Physicians Serving Uninsured and Underinsured Patients

The AMA continue to explore alternative methods of compensation for physicians who treat the indigent or uninsured or underinsured. (CMS Rep. 5, I-02)

D-385.983 Pay Disparity For Active Duty Physicians In The United States Military

Our AMA: (1) actively lobby Congress to increase the financial compensation of uniformed physicians to make it financially feasible for the long-term retention of qualified physicians; and (2) communicate its support for such increases in uniformed physician compensation directly to the Surgeons General of the three branches of the armed services. (Res. 909, I-02)

D-385.984 ERISA Preemption and State Prompt Pay Laws

(1) Our AMA continue to actively work with constituent societies to advocate for strong prompt payment laws, as well as full enforcement and implementation of those laws.

(2) Our AMA Advocacy Resource Center disseminate information to the Federation regarding the issue of Employee Retirement Income Security Act preemption and state prompt pay laws, including specific guidance for drafting legislation to best avoid preemption.

(3) Our AMA continue to seek legal avenues for advancing the case against ERISA preemption of state prompt pay laws.

(4) Our AMA monitor developments with regard to implementation of the U.S. Department of Labor claims processing regulation and provide information to the federation on any significant developments. (BOT Rep. 16, I-02)

D-385.986 Payment For Sonography

Our AMA, in collaboration with other specialty societies, shall vigorously advocate with Medicare and other payers that all appropriately trained physicians regardless of specialty be reimbursed for performing diagnostic sonography with appropriate documentation (including sonographically directed biopsy, aspiration, etc.) in situations with defined clinical indications. (Res. 108, A-02)

D-385.987 Hospital and Physician Reimbursement for Uncompensated Care, Teaching and Research

Our AMA will study current methods by which hospitals and physicians are paid for uncompensated care, teaching and research, and then consider whether, and if so how, to promote an appropriate funding mechanism. (Res. 810, I-01)

D-385.988 Compensation for Coumadin Management

Our AMA will request insurers, including Medicare, to allow physician reimbursement for Coumadin management. (Res. 118, I-01)

D-385.989 AMA Prompt Payment Initiative

The Federation be encouraged to disseminate this report to highlight the activities initiated by our AMA and organized medicine to actively confront and address delays in payments to physicians by health insurers. (BOT Rep. 35, A-01)

D-385.990 Supplemental Medicare Insurance Reimbursement

Our AMA will: (1) encourage the federal Department of Health and Human Services' Office of the Inspector General to investigate and prosecute, as appropriate, any Medigap insurers engaged in the practice of selling policies to Medicare beneficiaries that pay below the Medicare level and contain coordination of benefits provisions that avoid responsibility for co-payments and deductibles; and (2) take appropriate steps to expose unfair coordination of benefit practices by Medicare secondary payers. (Sub. Res.104, A-01)

D-385.991 Contact Capitation of Specialists

Our AMA will widely disseminate the information contained in this report so that physicians may better understand and prepare for contact capitation and other compensation arrangements that transfer risk from payers to providers. (CMS Rep. 1, A-01)

D-385.992 Medicaid as a Secondary Payer

Our AMA will support federal action to create an automatic claim crossover system for Medicaid. (Res. 128, A-00)

D-385.993 Medicare Global Surgical Guidelines

Our AMA will use its office and its persuasive ability to bring an end to the unilateral and unfair reimbursement methods being used by carriers and insurance companies in efforts to reduce surgical reimbursement. (Res. 106, A-00)

D-385.994 Managed Care Organization Reimbursement Formulas

Our AMA will continue to develop resources that serve to assist physicians in reviewing and understanding their contractual agreements, including payment methodologies. (CMS Rep. 6, A-00)

D-385.995 Financial Incentives by Managed Care Systems on Patients

Our AMA: (1) BOT will make a clear statement to reaffirm that health care delivery systems should not be permitted to place physician financial incentives to limit care over patient care interest;

(2) BOT will make a clear statement, which states that physician financial incentives should be awarded for providing high quality patient care rather than providing desirable financial profiles for limiting care;

(3) BOTasks the CEJA to review the ethical concerns involved in health care delivery systems that encourage, promote, or advocate physician financial incentives to limit care provided to patients; and

(4) report back at the 2000 Interim Meeting. (Res. 1, A-00)

D-385.996 Socioeconomic Factors Influencing the Patient-Physician Relationship

Our AMA will report on the impact that Medicare payment policies have had on the ability of physicians to provide patient care and the resulting effect on the patient-physician relationship. (CMS Rep. 7, I-99)

D-385.998 Private Sector Advocacy Activities Update

Our AMA will continue to aggressively advocate in the private and public sector to level the playing field between physicians and health care payers including the development of a negotiating unit, free of antitrust constraints, within organized medicine and with no affiliation with national trade unions, as advocated by Substitute Resolution 258 (A-98) and report back at A-99. (BOT Rep. 36, I-98; Reaffirmation A-04; Reaffirmation A-05)

D-390.000 Physician Payment: Medicare

D-390.962 National Care Project Physician Input

Our AMA (1) will provide education via established means to providers at acute and post acute levels in the Post Acute CARE (Continuity Assessment Record and Evaluation) demonstration project currently underway; and (2) urges the Centers for Medicare and Medicaid Services (CMS) to solicit local, state, and national physician input during the CMS CARE demonstration period (2008-2011). (Res. 833, I-08)

D-390.963 Improving the Medicare Economic Index

Our AMA will urge the Centers for Medicare and Medicaid Services and the Medicare Payment Advisory Commission to review the Medicare Economic Index productivity offset and consider eliminating it or revising it so that it more accurately reflects the effects of productivity increase in medical practice. (CMS Rep. 6, I-08)

D-390.964 Emerging Medicare Physician Payment Methodologies

Our AMA (1) will forward the testimony and comments from Reference Committee and House of Delegates discussions regarding the alternative Medicare payment methodologies outlined in Council on Medical Service Report 4-I-08 to the Council on Medical Service for consideration in developing its recommendations for a follow up report at the 2009 Annual Meeting, and (2) encourages members of the House of Delegates, state medical associations, and national medical specialty societies to forward any additional comments on the alternative Medicare payment methodologies outlined in Council on Medical Service Report 4-I-08 to the Council on Medical Service by January 9, 2009. (CMS Rep. 4, I-08)

D-390.965 Sustainable Growth Rate and Medicare

Our AMA: will (1) continue to express its extreme disappointment in the failure of the US Congress to protect access to medical care for Medicare beneficiaries by ensuring a fair and reasonable physician payment update; and (2) report back to the AMA House of Delegates at the 2008 Annual Meeting on the progress of major Medicare reform. (Res. 707, I-07)

D-390.966 Inappropriate Changes to Physician Medicare Participation Status by the Centers for Medicare & Medicaid Services

Our AMA will work with the Centers for Medicare and Medicaid Services, when necessary, to:

a. return physicians to their self-designated Medicare non-participation status in those cases where CMS changed physicians from “non-participating” to “participating” status without the physicians’ request or permission;

b. have the agency provide written documentation of the erroneous change in the physicians' Medicare participation status thereby allowing those affected physicians to prove that they had no part in the appearance of fraudulent activity resulting from the erroneous CMS action; and

c. have the agency provide written documentation of the erroneous change in the physicians' Medicare participation status thereby allowing those affected physicians to prove their innocence to their patients and to all of the Medigap providers whose erroneous explanation of medical benefits forms now imply wrongdoing by these non-participating physicians. (Res. 105, A-07)

D-390.967 Elimination of Subsidies to Medicare Advantage Plans

1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services, and that any savings from the elimination of subsidies to private plans be used to address the Sustainable Growth Rate (SGR).

2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans. (Res. 229, A-07)

D-390.968 Educate the Public on Potential Lack of Access to Health Care for Medicare Recipients

Our AMA will: (a) work to ensure that the February 2007 National Advocacy Conference provides a highly effective forum to educate public policy makers, the public and the media about the need for long-term Medicare physician payment reform; (b) work with state medical societies to schedule programs throughout the year in the states aimed at educating the local population, patients, policy makers and the media about the impact of the pending Medicare physician payment cuts on access to care in those states; and (c) evaluate the need for an additional program in Washington, DC, at a later date in 2007, if another opportunity for face-to-face advocacy by physicians from across the country with their representatives in Congress is deemed necessary to successful achievement of the AMA's Medicare payment advocacy objectives for 2007. (BOT Action in response to referred for decision Res. 912, I-06; Reaffirmation A-07)

D-390.969 Parity in Medicare Reimbursement

Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the Medicare physician payment formula, the sustainable growth rate (SGR); (2) repeal or delay the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (3) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (4) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08)

D-390.970 Recovery Audit Contractor Appeals

Our AMA will: (1) educate state medical societies and AMA-member physicians about the available methods for administrative and judicial appeals of Recovery Audit Contractors overpayment recoveries; (2) define common appeal scenarios and methods of appeals, provide technical support on appeals, and seek to consolidate cases for appeal with assistance of state medical societies via the AMA Litigation Center; and (3) continue to oppose the Recovery Audit Contractors' pilot projects and reaffirm existing policy D-390.972. (Sub. Res. 603, I-06)

D-390.971 Medicare Reimbursement for Anesthesiologists

Our AMA will continue its advocacy to replace the flawed SGR payment formula, resulting in increases to the Medicare conversion factors and payments to all physicians. (BOT Action in response to referred for decision Res. 718, I-05)

D-390.972 Recovery Audit Contractors

Our AMA will work with Congress to seek to overturn the mandate for the Centers for Medicare and Medicaid Services to continue the services of the Recovery Audit Contractors' pilot projects in Florida, New York and California. (Res. 214, A-06; Reaffirmed: Sub Res. 603, I-06)

D-390.973 Opting Out of Medicare Information Dissemination

Our AMA will place on the members-only section of the AMA web site a link to the information outlining the steps physicians need

to take in order to opt out of Medicare. (Sub. Res. 106, A-06)

D-390.974 Modes of Participation in Medicare and Their Impact on the Patient, the Physician, and the US Congress

Our AMA will:

(1) continue working to identify politically viable modifications to the statutory language on private contracting that will make opting out a more reasonable choice for practicing physicians; and

(2) educate physicians on the different options for participating in the Medicare program and provide our members with the tools and information necessary to analyze the impact on their patients, their practice, and the US Congress, of their choice of the three modes of relating to the Medicare program by:
(a) opting out of Medicare; or
(b) caring for Medicare patients in a fee-for-service relationship, making the decision to "accept assignment" on the basis of mutual needs of the patient and the physician; or
(c) continuing as a "participating physician" in the Medicare program understanding that the physician is subject to the continued anticipated reductions in direct reimbursement and the ultimate inability to directly negotiate any fees on behalf of their practice. This may give Congress the wrong impression that there is no problem with continued fee reductions. (BOT Rep. 16, A-06)

D-390.975 Payment for Facilities Expenses in Physicians' Offices

Our AMA will (1) advocate that CMS increase allowed expenditures subject to the SGR target whenever CMS assigns new office expenses to codes that historically have only been performed in the hospital; and (2) incorporate this recommended administrative change into the other SGR system changes our AMA has advocated, such as removing drug spending from the SGR system and recognizing new coverage decisions. (BOT Action in response to referred for decision Res. 115, A-03)

D-390.976 Medicare Physician Payment

Our AMA will send all members of Congress a letter, signed by all willing members of the Federation, urging them to enact legislation replacing Medicare's sustainable growth rate reimbursement formula with a system based on appropriate updates. (BOT Rep. 35, A-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation I-08)

D-390.977 Medicare's Sustainable Growth Rate Formula and Pay-for-Performance

Our AMA will actively lobby for any legislative or regulatory changes necessary to ensure that any Medicare Part A savings which are achieved when physicians' efforts result in fewer in-patient complications, shorter lengths-of-stays, fewer hospital readmissions, etc., are "credited" and flow to the Part B physician payment pool. (Sub. Res. 220, A-05; Reaffirmation A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06

D-390.978 CMS Establishment of Safe Harbor Methodologies Affecting Reimbursement for Medical Director Services in Violation of the Administrative Procedures Act

Our AMA will (1) work with Congress to compel the Centers for Medicare and Medicaid Services to allow for the full comment and review process to occur before implementing changes in medical director reimbursement; and (2) seek cessation of implementation of the recent policy establishing a safe harbor for development of medical director reimbursement. (Res. 111, A-05)

D-390.979 Economic Impact of Shifts in Site of Service

Our AMA will strongly advocate that, should the Sustainable Growth Rate formula continue to be used, the Centers for Medicare and Medicaid Services increase the SGR target to take into account procedures that are newly priced in the office setting, and continue to analyze the shift in site of service of these procedures to determine if the SGR target adjustments are accurate. (CMS Rep. 4, A-05)

D-390.980 The Economic Impact on Physician Reimbursements of the Shifting of Inpatient Medicare Part A Services to Outpatient Medicare Part B Services

Our AMA will (1) study the effect on physician reimbursements of the shifting of open-ended inpatient Medicare Part A services to capped outpatient Medicare Part B services; and (2) pursue all appropriate legislative and/or regulatory action to correct for both prior and ongoing physician losses under Medicare Part B reimbursements if a study reveals that there is a significant decrease in physician reimbursement resulting from the shifting of open-ended inpatient Medicare Part A services to capped outpatient Medicare Part B services. (Res. 106, A-04)

D-390.981 Medicare Payment for Services to Skilled Nursing Facility Residents in Physicians' Offices

Our AMA will:
(1) inform the Centers for Medicare and Medicaid Services of the problems physicians and their patients experience as a result of the inclusion of the technical component of physicians' office-based services in the consolidated billing protocol for Medicare Skilled Nursing Facility residents;
(2) urge the Centers for Medicare and Medicaid Services (CMS) to provide greater oversight of Medicare Skilled Nursing Facilities (SNFs) in meeting their obligations to pay physicians for the technical component of services those physicians provide in their offices to Medicare SNF residents;
(3) advocate to Congress that it exclude from Medicare's Skilled Nursing Facility (SNF) consolidated billing protocol the technical component of medical services provided in physicians' offices to Medicare SNF residents, because of concern with the negative impact on care that could potentially occur;
(4) urge the Centers for Medicare and Medicaid Services to require SNFs to clearly identify those patients who fall under the Medicare SNF consolidated billing program, as opposed to non-skilled extended care facility (ECF) patients, prior to sending patients to physicians' offices for care; and
(5) communicate to physicians that in order to assure payment whenever a SNF resident receives a service that is subject to SNF consolidated billing, the SNF and the physician are required to enter into an arrangement prior to providing services and the physician must look to the SNF for payment. (CMS Rep. 1, A-04)

D-390.982 Asking Congress to Fix the CMS Physician Payment Formula

Our AMA will: (1) continue to lobby Congress to enact legislation, before the 2004 Medicare update, that will make ongoing corrections to the Medicare physician payment formula; and (2) expand its efforts to inform grassroots physicians of this ongoing problem and help organize efforts to encourage all physicians to contact their Senators and Representatives. (Res. 130, A-03)

D-390.983 CMS Pharmaceutical Reimbursement Method

Our AMA will work to exclude pharmaceutical costs from the Sustainable Growth Rate formula. (Res. 111, A-03)

D-390.984 Payment by Health Insurance Plans of Medicare Deductibles and Copayments

Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; (2) advise physicians that they are legally entitled to the Medicare co-payments and are required to bill the patients for them, because of existing Medicare fraud and abuse laws, and report back at the 2003 Interim Meeting to membership on the legality and measures that physicians may take when secondary carriers will not pay, and this does not apply to Medicare and Medicaid dual eligibles; and (3) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary. (Res. 105 and 106, A-03)

D-390.985 Medicare Balance Billing

Our AMA will (1) work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate; and (2) evaluate the potential impact of the Medicare burden on its members in order to save health care for all Americans if the federal government denies the right to balance bill Medicare patients. (Res. 119, A-03; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06)

D-390.986 Medicare Balance Billing

Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing. (Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06)

D-390.987 Medicare Payment For Critical Care Services

The AMA shall continue to aggressively pursue legislative changes to fix the Medicare physician payment update problem. (CMS Rep. 4, I-02; Reaffirmation I-07)

D-390.988 Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error

Our AMA: (1) send a written communication to every United States Senator expressing physician anger and frustration with the Senate's failure to correct documented errors in physician payment. This communication should also reiterate physician concerns that

failure to correct documented mistakes is creating serious access problems for Medicare patients;

(2) in conjunction with state and national medical specialty societies, immediately distribute materials for display in physician offices alerting patients and their families to an access meltdown as result of inaction by the U.S. Senate; patients and physicians will be urged to contact their Senators by using the toll-free AMA Grassroots hotline (1-800-833-6354), to produce the greatest possible volume of contacts during Senate business hours in concert with the proposed Washington Fly-In;

(3) coordinate a Washington Fly-In in early January 2003 with state and national medical specialty groups, group practices and other health professional groups to urge Congress to immediately enact legislation to avert additional Medicare payment cuts that will further erode patient access to care; state and county societies are also encouraged to host similar events in January 2003 at the local level;

(4) assist state and national medical specialty societies and group practices in hosting physician practice days, or "mini-internships," for Members of Congress and their staffs between mid-December, 2002, and January 7, 2003, when Congress reconvenes; inviting Members of Congress and their staff to spend a day in a physician office will enable policymakers to understand the urgency of the physician payment problem;

(5) expand communications activities through the use of the House Call program and paid media to educate the public on the need for immediate action by Congress;

(6) aggressively promote expanded grassroots participation in the Medicare Update Campaign through the use of blast fax, e-mails and the toll-free grassroots hotline (1-800-833-6354);

(7) continue to work with state and national medical specialty societies, as well as group practices, on physician surveys to measure the effect on patient access to care;

(8) immediately disseminate the latest information to physicians regarding Medicare participation, non-participation and private contracting arrangements;

(9) reiterate our thanks and appreciation to Rep. Bill Thomas, Rep. Billy Tauzin, Rep. Nancy Johnson, Rep. Mike Bilirakis , Sen. Bill Frist and Sen. Jim Jeffords for their leadership in efforts to stop unfair and outrageous Medicare cuts; and

(10) concurrent with all of the above legislative, grassroots and targeted political actions, continue to evaluate aggressive, appropriate legal remedies through court action that could serve to rectify physician concerns about Medicare payment cuts and their impact on patient care. (BOT Rep. 24, I-02)

D-390.989 Equal Pay for Equal Work

Our AMA will work to eliminate the unfairness inherent in the current wide geographic disparity in physician Medicare reimbursement. (BOT Rep. 14, A-02)

D-390.990 Medicare Physician Payment Schedule Formula

Our AMA shall challenge the Centers for Medicare and Medicaid Services on its formula calculations and determinations of physician reimbursement, including the possibility of a class action suit on behalf of AMA members and report back by the 2002 Interim Meeting on its progress. (Res. 128, A-02; Reaffirmation A-06)

D-390.991 Address Congress' Arbitrary Cuts in Medicare

Our AMA shall negotiate an immediate resolution of Congress' arbitrary reduction of Medicare physician reimbursement by 17 percent by 2005. (Res. 131, A-02)

D-390.992 Automatic Claims Processing by Medicare Contractors

Our AMA will seek a change in federal law that would require any insurer that provides supplemental Medicare coverage, to contract with Medicare contractors to accept electronic or manually transmitted claims that indicate the Medicare allowable payment and the physician's charge with the remainder due. (Res. 104, I-01)

D-390.993 Medicare Reimbursement of Preventive Services

Our AMA will: (1) advocate with the United States Congress for Medicare reimbursement of preventive services; and (2) investigate how Medicare coverage can be extended to evidence-based clinical preventive services without having to change federal law for each

preventive service to be covered. (Res. 113, I-00)

D-390.994 Prompt Payment under Medicare+Choice

Our AMA will: (1) forward a letter to CMS requesting that regulations be promulgated to extend standard Medicare fee-for-service plans payment guidelines of 14 days and 28 days for electronic and paper claims respectively to all Medicare+Choice programs; and (2) urge CMS that an interest penalty be applied for failure to pay within Medicare prompt payment guidelines. (Res. 106, A-01)

D-390.995 Authorized Assignment of Benefits

Our AMA will seek: (1) legislation or regulation, or develop model state legislation to ensure that third party payers be required to issue payment directly to providers when the patient has signed an authorization for the assignment of benefits; and (2) legislative relief mandating that health plans notify physicians when claim payments are issued to the insured rather than the physician who has an assignment agreement. (Res. 127, A-00)

D-390.996 Acquire CMS Criteria for Improper Payment

Our AMA will acquire CMS criteria for improper payments and share them with component societies and member physicians. (Res. 111, A-00)

D-390.997 CMS Practice Expense Formula

Our AMA will seek from Congress legislation directing CMS that it include in the RBRVS practice expense allocation all costs incurred by physicians, including those costs incurred in hospitals and ambulatory surgical centers. (Sub. Res. 819, I-99)

D-390.998 Impact of Changing to Medicare Nonparticipating Status

Our AMA will develop and distribute a worksheet for use by its members to assess the financial impact of Medicare in their practices, including costs and risks of participation versus non-participating, and instructions on how to become non-participating if any member so elects. (Res. 124, I-99)

D-390.999 Universal Explanation of Medical Benefits Forms

Our AMA, in collaboration with relevant members of the National Uniform Claim Committee (NUCC), will develop standard explanation of medical benefits forms that are consistent with existing policy. (Sub. Res. 106, I-98; Modified and Reaffirmed: CMS Rep. 4, A-08)

D-400.000 Physician Payment: Medicare - RBRVS

D-400.985 Geographic Practice Cost Index

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); and (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs). (Sub. Res. 810, I-08)

D-400.986 The RUC: Recent Activities to Improve the Valuation of Primary Care Services

Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee (RUC) recommendations, and separate payment for physician services that do not necessarily require face-to-face interaction with a patient. (BOT Rep. 14, A-08)

D-400.987 Potential Limitation to Access of Care for ESRD Patients

Our AMA will: (1) immediately petition the Secretary of the Department of Health and Human Services, to rescind the current proposed changes in reimbursement for nephrology;

(2) encourage Congress, if necessary, to enact legislation to address the proposed reimbursement changes for nephrology;

(3) suggest to Congress and the Centers for Medicare and Medicaid Services (CMS) that reimbursement for nephrology services to patients with End Stage Renal Disease (ESRD) undergo study via a demonstration project; and

(4) strongly exert its influence to CMS that reimbursement issues for all of organized medicine should not circumvent the Current

Procedural Terminology (CPT) and the AMA/Specialty Society Relative Value Update Committee (RUC) processes. (Res. 730, I-03; Reaffirmation I-04)

D-400.988 PLI-RVU Component of RBRVS Medicare Fee Schedule

Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula;

(2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding;

(3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion; and

(4) report back to the House of Delegates at the 2004 Annual Meeting on the progress of the activities pertaining to PLI-RVU portion of the RBRVS. (Res. 707, I-03; Reaffirmed: BOT Rep. 18, A-05)

D-400.989 Equal Pay for Equal Work

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option. (BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08)

D-400.990 Uncoupling Commercial Fee Schedules from Medicare Conversion Factors

Our AMA shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement (Res. 137, A-02)

D-400.991 CPT Modifiers

(1) Our AMA will continue to actively collect information, through existing processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data collection from other interested members of the Federation on the acceptance of CPT modifiers by third party payers.

(2) Pertinent information collected by our AMA through existing methods and collected through the AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be shared with applicable state, county and national medical specialty societies in order to promote a greater understanding of third party payer payment policies related to CPT modifiers.

(3) Our AMA use the available information to engage in discussions with payers.

(4) Aggregate information collected through existing methods and collected through the AMA PSA Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be disseminated to state and federal regulators and legislators.

(5) Our AMA provide the House of Delegates with an update on the acceptance for payment of CPT modifiers, as well as pertinent CPT coding abuses by third party payers at the 2003 Annual Meeting. (Sub. Res. 808, I-01)

D-400.992 Medicare Conversion Factor

Our AMA: (1) will take as an immediate priority the pending decrease of the Medicare Conversion Factor to be implemented January 1, 2002; and (2) in conjunction with other organizations who share the same concerns, particularly those that represent beneficiary interests; begin to work with Congress and the Centers for Medicare and Medicaid Services (CMS) to redesign the methodology used to calculate the conversion factor. (Res. 106, I-01)

D-400.993 Coding and Valuation of Medicare Emergency Medical Services and Inpatient Hospital Services

Our AMA will urge that the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) to investigate the need to develop additional CPT codes and/or relative values, as appropriate, and that the Centers for Medicare and Medicaid Services pay for: (1) the provision of emergency medical services and inpatient hospital services provided to the same patient by the same physician or a different physician with the same provider number, including, but not limited to, services provided on the same date; and (2) the provision of emergency medical services during off-hours by physicians in hospitals without full-time emergency room coverage. (Sub. Res. 117, A-01)

D-400.994 Conscious Sedation

Our AMA will support the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) as they review the coding and valuation issues related to procedures that are performed using moderate sedation/analgesia (i.e., "conscious sedation"). (Res. 107, A-01)

D-400.995 Medicare National Physician Payment Schedule and Coordination of Benefits

Our AMA: (1) continues to distribute its Model Managed Care Contract to physicians and redistribute the model state legislation to state medical associations to help ensure that physicians will receive the full Medicare deductible or coinsurance amount when a third party payer is the secondary payer to Medicare; (2) for the purpose of developing additional litigation and advocacy strategies, develop and disseminate to state medical associations a survey tool that will enable them to: (a) determine if third party payers are inappropriately coordinating benefits in their states; (b) identify which payers are involved; and (c) if possible, identify the employers that may or may not be aware of this practice; and (3) encourage state medical associations to submit to our AMA specific cases in which physicians are denied payment when a third party payer is the secondary payer to Medicare, and Our AMA analyze a potential litigation strategy for these cases based on actual contract terms, contracting structure, and other factors that may impact the viability of a potential legal action. (CMS Rep. 2, A-01)

D-400.996 Halt Transition of Medicare Practice Expenses

Our AMA: (1)d will seek Congressional action if sufficient funding can be obtained through the current budget surplus to increase the money allocated to the Medicare Physician Fee Schedule, for the purpose of seeking a halt to the amendments of the practice expense provisions of the Medicare law at the 2000 level (50% 1998 PE RVUs blended with 50% proposed 2002 PE RVUs), except for the office visit and office consultation codes, which would continue to increase to their projected 2002 levels; and (2) If sufficient funding cannot be obtained, that our AMA continue to support the transition of Medicare practice expenses. (Sub. Res. 130, A-00)

D-400.997 Relative Value Unit Change for Critical Care Codes 99291/99292

Our AMA reaffirm existing policy H-400.962 and will protest CMS decision to not adopt the AMA/Specialty Society RVS Update Committee (RUC) recommendation for codes 99291 and 99292 in written comments to the November 2, 1999 Final Rule which established interim values for these services. (Sub. Res. 821, I-99)

D-400.998 Pediatric CPT Coding

Our AMA reaffirm existing policy H-400.959 (1) and that a progress report on this issue be provided to the House of Delegates at the 2000 Annual Meeting. (Sub. Res. 816, I-99)

D-400.999 Non- Medicare Use of the RBRVs

Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;.

(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;

(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;

(4) strongly oppose and protests any efforts by third party payers and other public programs to redefine the Centers for Medicare & Medicaid Services's Medicare multiple surgery reduction policy by reducing payment for additional surgical procedures after the first procedure by more than 50%; and

(5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the

calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS. (CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07)

D-405.000 Physicians

D-405.991 Clarification of the Title "Doctor" in the Hospital Environment

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, "that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine") must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

4. Our AMA will study the feasibility and benefits of a Public Education campaign to include: 1) education of the public on the use of the terms "Doctor" and "Physician" as related to various health care providers within the Health Care setting; 2) the promotion of public awareness of the term "Physician" by developing an "Is your Doctor a Physician" program; and 3) the availability of quality name tags, available to AMA member physicians only for a reasonable fee, containing the AMA Logo (as part of the overall physician advocacy/branding campaign), the member physician's name and degree (M.D., D.O.), photo and the highlighted subtitle- "Physician", and report their findings and recommendations to the House of Delegates at or before the 2009 Interim Meeting. (Res. 846, I-08)

D-405.992 Physician Health and Wellness

Our AMA: (1) supports programs related to physician health and wellness, including those offered in conjunction with the Federation of State Physician Health Programs; (2) will convene those interested in medical education in an effort to bring the dialogue about healthy lifestyle and balance early in the careers of medical students and residents; and (3) considers the concept of physician wellness as an element of the AMA Strategic Plan. (Res. 609, A-08)

D-405.993 Defining "Loss of Practice" in Catastrophic Events

Our AMA: (1) will continue to seek and promote products that cover physicians in the case of the loss of physician practices and practice income following catastrophic events and educate physicians on disaster recovery solutions; and (2) encourages state medical associations and national medical specialty societies to develop products and educational services to assist members with disaster recovery solutions. (CMS Rep. 6, A-07)

D-405.994 Pending Litigation Regarding Medical Errors

Our AMA Board will observe how these cases progress. (BOT Action in response to referred for decision Res. 734, A-06)

D-405.995 Defining "Loss of Practice" in Catastrophic Events

Our AMA will study how the insurance industry defines loss of practice in situations resulting from major catastrophes. (Res. 731, A-06)

D-405.996 Physician Well-Being and Renewal

Our AMA will work with the Federation of State Physician Health Programs to establish and promulgate a networking resource/database and web site clearinghouse for Medical Staff Physician Health Committees or their equivalents in physician groups throughout the country, and to provide resources that will allow such committees to proactively initiate programs of wellness and

illness prevention for physicians. (Res. 409, A-03)

D-405.997 Truth in Advertising

Our AMA shall inform its members and the general public of this policy and published lists of "Best Physicians" should include a full disclosure of the selection criteria, including direct or indirect financial arrangements. (Sub. Res. 9, A-02)

D-405.998 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will encourage all members to register for participation in AMA Member Connect surveys, in order to voice their concerns on matters of importance to physicians, by calling (800) 337-1599. (CMS Rep. 6, I-01)

D-405.999 Retirement Plan Legislation

Our AMA will focus a lobbying coalition with all professional groups thus affected, to vigorously support legislation to raise allowable pension plan contributions and index subsequent increases to inflation. (Res. 235, A-99)

D-406.000 Physician-Specific Health Care Data

D-406.994 Safeguard National Provider Identifier and Physician Privacy

Our AMA will develop and mandate adequate safeguards for the protection of physician privacy, such as those used by the banking industry, showing only the last four digits of the National Provider Identifier number on publicly accessible web sites and in published lists. (Res. 710, A-08)

D-406.995 Safeguard NPI and Physician Privacy

Our AMA will advocate for an approach that restricts NPI access to those with a legitimate need for these numbers and pursue a strategy that minimizes the amount of information released in association with each NPI number. (BOT Action in response to referred for decision Res. 730, A-07)

D-406.996 Insurance Company Economic Profiling of Physicians

Our AMA will: (1) take all appropriate steps to actively oppose all efforts by third party payers to rank, profile or otherwise “score” physicians purely for corporate cost containment purposes; and (2) widely publicize insurance industry economic profiling practices and how they impact patient care and access. (Res. 820, I-07)

D-406.997 One Fee, One Number

Our AMA will study the need for, financial impact of, and possible elimination of, multiple physician identifiers (e.g. DEA, NPI, State License Numbers, insurance company identification numbers). (Res. 701, I-07)

D-406.998 National Provider Identification

Our AMA will work closely in consultation with the Centers for Medicare and Medicaid Services to introduce safeguards and penalties surrounding the use of National Provider Identification to protect physicians’ privacy, integrity, autonomy, and ability to care for patients. (Res. 717, I-04)

D-406.999 The Collection of Physician and Patient Specific Data by Pharmaceutical Companies

Our AMA will explore: (1) the current scope of physician- and/or patient-specific data collected by the pharmaceutical industry; (2) current use of such data, and the impact of such practices on the cost and quality of health care; and (3) recent incidents where identifiable patient data were apparently purchased, procured and/or otherwise obtained and used for marketing purposes. (Res. 604, I-03)

D-410.000 Practice Parameters
(See also: Health Care Reform; Quality of Care)

D-410.996 Physician Seeking Regulation of Physicians

Our AMA will, with the intent of improving patient care and promoting interspecialty collaboration, develop a process for national specialty groups to urge their state affiliates to work through the state medical association prior to the introduction of any state legislation that seeks to regulate or restrict the practice of other physician groups or specialties. (Res. 235, A-08)

D-410.997 Criminalization of Physician Departure from Guidelines and Standards

Our AMA will study and report back at the 2005 Annual Meeting as to:

(1) the need for a national clarification of the terms guidelines (parameters, algorithms, etc.) vs. standards (mandating compliance) for medical care and resource allocation;

(2) the legal, moral, and ethical impact of appropriate departure from guidelines or standards, the clarification of what constitutes appropriate departure, and the rights of physicians and other health care providers accused of non-compliance with a guideline or standard; and

(3) the legal, moral and ethical impact of the criminalization of medical decisions and actions of physicians and other health care providers who appropriately depart from such guidelines and standards. (Res. 718, I-04)

D-410.998 Quality Patient Care Measures

Our AMA: (1) seek adequate expert physician representation, meaningful dialogue and input to all bodies developing measures for quality patient care, safe practice and performance;

(2) advocate for wider support and funding for adequate collection of clinical data needed for the development of quality standards;

(3) encourage the Physician Consortium for Performance Improvement to move ahead in a proactive and highly visible manner to address these quality and safety concerns;

(4) move to gain active involvement by all national specialty societies in the activities of the Physician Consortium for Performance Improvement; and

(5) advocate that the measures developed by the Physician Consortium on Performance Improvement be tested in practice via demonstration projects prior to broad implementation. (Res. 811, I-02)

D-410.999 American Medical Accreditation Program (AMAP)

(1) Our AMA (a) continue its leadership and convenor roles in developing the professional standards that govern medical practice; (b) continue to aggressively develop clinical performance measures that facilitate physician continuous quality improvement; and (c) continue to explore ways to collaborate with others on performance measurement and quality improvement activities. (2) A report on performance measurement and quality improvement be provided to the House of Delegates at the 2000 Interim Meeting. (BOT Rep. 19, A-00)

D-420.000 Pregnancy and Childbirth
(See also: Infants; Children and Youth)

D-420.994 Racial and Ethnic Disparities in Maternal Mortality

Our AMA will:
(1) work with other interested organizations, such as the Centers for Disease Control and Prevention, to seek increased public and private funding to support educational efforts to expand awareness of providers, hospitals, and patient organizations about the increasing risk of maternal mortality in the United States, and the importance of preconception care to reduce these risks;
(2) work with other interested organizations to seek increased public and private funding to study racial disparities in maternal mortality in the United States; and
(3) report back on these efforts at the 2009 Annual Meeting. (Res. 511, A-08)

D-420.995 Use of Serotonin Reuptake Inhibitors in Pregnancy

1. Our AMA encourages further research into the treatment of depression during pregnancy, including the effects of antidepressant drugs, as well as strategies designed to best protect the health and welfare of both the mother and the child.

2. Our AMA Council on Science and Public Health will monitor the activities of relevant medical specialty societies on this issue, including development of practice guidelines or policy statements, and assist as needed in educating the physician community.

(CSAPH Rep. 13, A-07)

D-420.996 SSRI Use During Pregnancy

Our AMA will work with all appropriate specialty societies to: (1) prepare a report summarizing the research on the use of SSRI antidepressants during pregnancy; and (2) promulgate appropriate guidelines concerning the detection and treatment of depression during pregnancy. (Res. 519, A-06)

D-420.997 Pain Relief During Labor & Delivery

Our AMA will work with the American Society of Anesthesiologists and other necessary stakeholders (e.g., Association of Women's Health, Obstetric and Neonatal Nurses) to ensure that patients receive the necessary pain relief during labor and delivery (Res. 530; A-03)

D-420.998 Use of Misoprostol for Cervical Ripening

Our AMA will ask the Council on Scientific Affairs to report on the safety, efficacy and value of misoprostol use in the third trimester of pregnancy, post partum period, and for fetal death in utero. (Res. 514, I-01)

D-420.999 To Amend The Family Leave Act

Our AMA will: (1) work with the Federal administration and/or Congress as appropriate, to return the Family Medical Leave Act to its original intended application; and (2) work to simplify the FMLA form, reducing the physician work required for completion. (Sub. Res. 203, I-00)

D-425.000 Preventive Medicine

D-425.994 Early Recognition and Intervention in Chronic Kidney Disease

Our AMA will recommend to the United States Preventive Services Task Force that it consider developing guidelines on the screening, diagnosis and staging of chronic kidney disease. (Sub. Res. 521, A-08)

D-425.995 Newborn Screening: Challenges for the Coming Decade

Our AMA will: (1)support the report from the Newborn Screening Task Force, "Serving the Family from Birth to the Medical Home. A Report from the Newborn Screening Task Force," and recognize the authors of this report as the major stakeholders in the field of newborn screening; (2) support the Health Resources and Services Administration, Centers for Disease Control and Prevention, and the American College of Medical Genetics as they study the process of standardization of outcomes and guidelines for state newborn screening programs; and (3) monitor developments in newborn screening and revisit the topic as necessary. (CSA Rep. 4, I-01)

D-425.996 Implementing the Guidelines to Community Preventive Services

Our AMA will : (1) commend the Centers for Disease Control and Prevention (CDC) and the Task Force on Community Preventive Services for their work in developing the Guides to Community Preventive Services;

(2) review the recommendations and conclusions of the Task Force on Community Preventive Services and recommend to the House of Delegates the appropriate actions as per AMA policy;

(3) express to the Director of CDC our support for the establishment of a working group between the CDC and the AMA and our specialty organizations plan for promoting the implementation of the Guides to Community Preventive Services within the private medical sector; and

(4) promote the visibility of the recommendations of the Guides to Community Preventive Services as they become available, provided those recommendations comport with AMA policies and standards. (CSA Rep. 6, I-01)

D-425.997 Screening Standards

Our AMA, through the Council on Scientific Affairs, will study the process for endorsing or supporting coverage of screening standards and recommend a process for dealing with resolutions submitted to the House of Delegates that pertain to evaluations of screening standards. (Res. 505, I-00)

D-425.999 Public and Private Funding of Prevention Research

(1) Our AMA will work in partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and other Federal Agencies, the Public Health Community (via the medicine/public health initiative), and the managed care community to develop a national prevention research agenda and report back to the House of Delegates the current status of this agenda. (2) These groups work in partnership to develop a practical plan to implement recommendations which will allow such groups to support and participate more fully in prevention research. (Res. 418, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

D-430.000 Prisons
(See also: AIDS; Crime; Legal Medicine)

D-430.996 Opiate Replacement Therapy Programs in Correctional Facilities

Our AMA will support and develop model legislation in the jurisdiction where it is most feasible to institute voluntary (for inmates) opioid replacement treatment pilot programs, (including methadone and buprenorphine maintenance treatment) in jails and prisons and these programs will be accompanied by an evaluation process to determine whether such treatment modalities decrease recidivism, crime, and transmission of infectious diseases among populations at risk in incarcerated settings in the states being studied. (Res. 443, A-05)

D-430.997 Support for Health Care Services to Incarcerated Persons

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and

(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities. (Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00)

D-430.998 Health Care Standards in U.S. Correctional Facilities

Our AMA: (1) will research, evaluate, and make recommendations for the revision of the standards of health care being provided in correctional settings and detention facilities, including the standards for identifying appropriate professionals to serve this population, and including standards for screening, identification, and control of serious infectious illnesses; and (2) in conducting research and developing recommendations on standards for health care in correctional settings, consult with appropriate medical specialty societies and the National Commission on Correctional Health Care (NCCHC). (Res. 416, I-99)

D-430.999 Preventing Assault And Rape Of Inmates By Custodial Staff

Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process. (CSA Rep. 2, I-00)

D-435.000 Professional Liability

D-435.975 Blood Centers and Medical Liability

Our AMA will advocate that blood centers be covered under any health care liability reform legislation. (Res. 209, A-08)

D-435.976 Protection From Liability Arising From Care Rendered to Patients During Officially Declared Disasters

1. Our AMA will develop and disseminate to state medical societies model legislation to give qualified physicians (MDs and DOs) automatic medical liability immunity in the event of a state or federally declared disaster or emergency, unless it is proven by clear and convincing evidence that a physician acted with malicious intent, wanton disregard for a patient's well being, or similar willful

misconduct.
2. AMA's existing model state legislation, "An Act to Prohibit the Criminalization of Healthcare Decision Making," will be revised to proscribe conduct reflecting criminal intent, and specifically refer to physician volunteers responding to a federally declared emergency or disaster, without regard to whether the disaster occurs within a state where the volunteer physician is licensed to practice. (BOT Rep. 2, A-07)

D-435.977 Closed Claims Database

Our AMA encourages: (1) national medical specialty societies to develop closed claims databases where appropriate; and (2) the Agency for Healthcare Research and Quality to design a useful dataset that can help researchers to develop best practice guidelines. (BOT Rep. 12, A-06)

D-435.978 Loss of Medical Staff Privileges for Lack of "Tail Coverage"

Our AMA will:

(1) Approach the American Hospital Association (AHA) to assess interest in commencing a dialogue regarding professional liability coverage requirements for medical staff members; develop with the AHA mutually acceptable alternatives to physicians facing "forced voluntary resignation" from the medical staff for not purchasing "tail" coverage or requiring the mandatory purchase of "tail" coverage; and, establish guidance on a reasonable time-frame in which physicians can obtain tail coverage when required;

(2) Advocate for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent; and

(3) Support model medical staff bylaw language stating: "Where continuous professional liability insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement." (BOT Action in response to referred for decision Res. 537, A-04)

D-435.979 Impact of US Medical Liability Premiums on Clinical Medical Education

Our AMA will actively investigate the ongoing impact of the medical liability crisis on the availability of full-time and volunteer clinical faculty for undergraduate and graduate medical education. (CME Rep. 2, I-05)

D-435.980 Inclusion of Residents in Medical Liability Reform

Our AMA:

(1) officially supports the inclusion of all physicians, including unlicensed residents, in state and federal medical liability caps;

(2) will advocate for the inclusion of unlicensed residents in all pending and future federal medical liability reform legislation; and

(3) will work with state medical societies to advocate for the inclusion of unlicensed residents in all current, pending, and future state medical liability reform legislation. (Res. 907, I-05)

D-435.981 Limits on Non-Economic Damages and Contingency Fees

Our AMA will: (1) support federal legislation that does not preempt state medical tort reform laws that have contingency fee limits that are more restrictive than the MICRA limits on contingency fees; and (2) explore federal legislation that would correct inadequate state medical liability laws, while preserving proven effective state medical liability reforms. (Sub. Res. 214, A-05)

D-435.982 Frivolous Lawsuit Management

Our AMA will develop a plan to advocate to deter frivolous medical liability suits. (Sub. Res. 210, A-05)

D-435.983 Guam Professional Liability Crisis in Red Alert

Our AMA will (1) continue to work with the national specialty societies and state medical societies, as well as the medical societies of Guam and other US territories to reform the medical liability system and (2) assess the inclusion of Guam and other US territories on the AMA's medical liability crisis map. (Sub. Res. 203, A-05)

D-435.984 Tort Reform

Our AMA will: (1) continue to pursue MICRA-based reform as the top priority; (2) continue to pursue liability reform efforts by any and all legislative options that would fundamentally change our medical liability system to create fair and equitable remuneration for injured patients and to promote patients' access to health care; and (3) report on its coalition building activities on efforts to reform our civil justice system and make this report available to the general membership by the 2005 Annual Meeting. (Sub Res. 921, I-04)

D-435.985 Use of Countersuits to Discourage Frivolous Lawsuits

Our AMA will advise members of the option for countersuits against plaintiffs and attorneys who have filed frivolous lawsuits against physicians. (Sub. Res. 914, I-04)

D-435.986 Risk Management Related to the Administrative Side of Care

Our AMA will work with appropriate stakeholders to promote risk management educational programs focused on the administrative procedures of medical facilities, including billing practices, to help reduce the number of medical malpractice suits filed. (Res. 701, I-04)

D-435.987 Medical Courts

Our AMA will draft an alternative judicial model for addressing medical liability claims based on special medical courts that are composed of judges trained in medical standards that could render more accurate decisions regarding whether medical malpractice has actually occurred and, if so, render a judgment as to the amount of monetary damages to be awarded. (Res. 916, I-03; Reaffirmation A-06)

D-435.988 Family Protection Act

Our AMA will: (1) propose amendments to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2003 (H.R. 975) which would provide further protections, including establishment of a minimum homestead exemption; (2) develop a strategy for promoting bankruptcy reform that is consistent with our AMA's efforts to promote medical liability reform; and (3) provide a report on actions taken to implement the above recommendations at the 2004 Annual Meeting. (BOT Rep. 9, I-03)

D-435.989 Family Protection Act

Our AMA will study potential mechanisms for legal reforms which would limit the use of an individual's personal assets to pay excessive liability awards with report back at the 2003 Interim Meeting. (Res. 205, A-03)

D-435.990 Delivery of Health Care by Good Samaritans

Our American Medical Association will work with state medical societies to educate physicians about the Good Samaritan laws in their states, and the extent of liability immunity for physicians when they act as Good Samaritans. (Res. 201, A-03)

D-435.991 Bioterrorism - Protection from Liability

Our AMA shall continue to work with the Congress to protect physicians from liability arising from providing medical care in an organized governmental response to bioterrorism. (Res. 409, A-02)

D-435.992 Liability Reform

Our AMA: (1) shall recruit a broad-based coalition composed of Federation members (state/county/specialty societies), trade and professional associations, small and large businesses, medical groups, farmers, non profit organizations, local governmental associations, patient advocacy groups and other supportive groups to promulgate a public information campaign on the issues of civil liability reform;

(2) and Federation members in their public and physician communication efforts, shall specifically highlight the problems emanating from the current tort milieu, develop a state by state impact analysis of litigation costs in the current system, and highlight key elements of proposed federal tort reform legislation;

(3) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate legislative relief from the current tort system to our congressional representatives and senators;

(4) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year;

(5) will form a liability reform task force as a central clearinghouse to actively coordinate and inform all of the states of best practices for obtaining significant liability relief for the doctors and patients of America, to include but not limited to expert witness rules, caps on non-economic damages, marketing by attorneys, and modification of contingency fees. The liability reform task force will bring to the 2002 Interim Meeting a plan for a national liability reform event; and

(6) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process. (Sub. Res. 215, A-02; Reaffirmation I-03; Appended: Sub. Res. 910, I-03)

D-435.993 No-Fault Malpractice System

Our AMA shall evaluate the concept of a no-fault medical liability system to help with the malpractice crisis nationally. (Res. 116, A-02)

D-435.994 The Rise in Professional Liability Insurance Premiums

Our AMA shall continue to monitor, analyze, and widely distribute data on professional liability insurance premiums (CMS Rep. 12, A-02)

D-435.995 Medical Care Online

Our AMA will educate physicians to be aware of clauses in their professional liability insurance coverage which may require them to report changes or additions to their practice-related activities, including the use or sponsorship of Web sites, e-mail, Internet discussion groups, and mailing lists. (CMS Rep. 4, A-01)

D-435.996 Malpractice Insurance Rate Increases and Physician Reimbursement

Our AMA will: (1) call upon the CMS to use current data in calculating the malpractice insurance portion of the Resource-Based Relative Value Scale and that this calculation take into account inter-specialty and geographic variances; and (2) study the calculated malpractice insurance portion of the RBRVS to determine the effect increasing malpractice insurance costs have on physician reimbursement. (Res. 109, A-01)

D-435.997 Guidelines for Review of Pap Smears in the Context of Potential Litigation

(1) Our AMA continues to support alternative dispute resolution (ADR) mechanisms and tort reforms consistent with AMA policy. (2) The CSA will study the issues that are raised by the use of the Pap smear as a screening test, its inherent limitations, the implications of a single false negative test, and the appropriateness of guidelines for the review of pap smears in the context of potential litigation and report back to the House of Delegates at the Interim 2000 meeting. (3) The AMA Council on Ethical and Judicial Affairs (CEJA) will examine the Guidelines for Review of Pap Smears in the Context of Potential Litigation as adopted by the Ohio Society of Pathologists to determine whether they are consistent with the ethical and judicial principles of the organization. (BOT Rep. 9, I-99)

D-440.000 Public Health

D-440.947 Support for Immunizations

1. Our AMA will provide materials on vaccine safety and efficacy to states and encourage them to enact more stringent requirements for parents/legal guardians to obtain personal belief exemptions from state immunization requirements.

2. Our AMA, in collaboration with the Immunization Alliance, will develop educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines.

3. Our AMA will communicate and work with other concerned organizations about effective ways to continue to support immunizations while rejecting claims that have no foundation in science. (Res. 922, I-08)

D-440.948 Advance Directive

Our AMA will work with members of Congress to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives. (Res. 922, I-07)

D-440.949 Dysmetabolic Syndrome and Type 2 Diabetes in Children

Our AMA (1) supports efforts to develop national-level data that would provide for the monitoring of the prevalence of diabetes among youth by type; and (2) encourages greater awareness by physicians of type 2 diabetes and its complications in children and will promote the availability of resources and information about the prevention and treatment of this growing public health threat. (Res. 418, A-07)

D-440.950 Support National Coalitions that Advocate for Increased Federal Funding for the Centers for Disease Control and Prevention

Our AMA will join the CDC Coalition and support the Campaign for Public Health. (Res. 441, A-07)

D-440.951 One-Year Public Health Training Options for all Specialties

1. Our AMA encourages additional funding for public health training for more physicians.

2. Our AMA, through its Council on Medical Education, will monitor the progress of the Institute of Medicine (IOM) study, Training Physicians for Public Health Careers, and provide an updated report based on the IOM study recommendations to the 2008 Annual Meeting.

3. Our AMA, in conjunction with other appropriate organizations, supports the work of relevant groups to initiate the development of specific physician competencies for physicians engaged in public health practice.

4. Our AMA will inform medical students and physicians of existing opportunities for physician training in preparation for public health practice. (CME Rep. 12, A-07)

D-440.952 Fighting the Obesity Epidemic

1. Our AMA Council on Science and Public Health (CSAPH) will critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting.

2. Our AMA will consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles.

3. Our AMA Council on Medical Service and CSAPH will collaborate to evaluate the relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35. (BOT Rep. 9, A-07)

D-440.953 Need for Action for Access to Immunization

1. Our AMA:

(a) will intensify its efforts to advocate that manufacturers and distributors make vaccines affordable to medical practices and ensure adequate and timely supply of vaccines to those practices;

(b) advocates that purchasers of health care provide their employees and other participants with first-dollar coverage for all Centers for Disease Control and Prevention (CDC)-recommended immunizations;

(c) advocates to public and private payers to pay for both the cost plus acquisition costs (storage, inventory, insurance, spoilage/wastage, etc.) of CDC-recommended vaccines and their administration with no patient cost-sharing;

(d) advocates to other appropriate organizations the need to assure that when immunizations are given in locations other than the patient's medical home, a process exists to ensure communication to the medical home and the state immunization registry documenting what immunizations have been given; and

(e) will study the impact on vaccine supply to medical practices, hospitals and other medical facilities that results from the large contracts with preferential distribution between vaccine manufacturers/distributors and large non government purchasers such as national retail health clinics with particular attention to patient outcomes for clinical preventive services and chronic disease management.

2. A report on the current status of these issues will be provided to the AMA House of Delegates at the 2008 Annual Meeting. (Res. 518, A-07; Reaffirmation A-08)

D-440.954 Addressing Obesity

Our AMA will: (1) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (2) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (3) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. (BOT Rep. 11, I-06)

D-440.955 Insurance Coverage for HPV Vaccine

Our AMA:
(1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;
(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations. (Res. 818, I-06)

D-440.956 Expanding the Vaccines for Children Program

Our AMA will work with its immunization partners to examine methods to improve financing mechanisms for vaccines, including the expansion of the Vaccine for Children program. (Res. 534, A-06; Reaffirmation A-07)

D-440.957 Distribution and Administration of Vaccines

Our AMA will work with the Centers for Disease Control and Prevention (CDC) and other appropriate partners to establish a comprehensive distribution system for all vaccines in the United States. (Sub. Res. 512, A-06)

D-440.958 Universal Defibrillator Connectivity

Our AMA will: (1) support the development and use of universal connectivity for all defibrillators; and (2) work with and support members of EMS departments, and state and federal legislators to strongly urge manufacturers to voluntarily adopt universal connectivity for all defibrillators. (Res. 511, A-06)

D-440.959 Community-Associated Methicillin Resistant Staphylococcus Aureus

Our AMA will work: (1) to raise physician awareness of Community-Associated Methicillin Resistant Staphylococcus Aureus (CA-MRSA), including distributing to all members the Centers for Disease Control and Prevention's strategies for management of CA-MRSA infections; and (2) with the CDC, the American Hospital Association, and other appropriate organizations and health agencies to educate physicians, hospital employees, schools, and the general public about prevention and treatment of CA-MRSA. (Res. 542, A-06)

D-440.960 Prohibiting the Sale of Tanning Parlor Ultraviolet Rays to Those Under 18 Years of Age

Our AMA will: (1) develop model state legislation to prohibit the sale of tanning parlor ultraviolet rays to those under 18 years of age except as prescribed by a physician and will widely disseminate this model legislation to its component societies; and (2) request that the FDA Center for Devices and Radiological Health immediately hold fair hearings on the safety and efficacy of ultraviolet-A (UVA) bulbs as used in indoor tanning facilities and make their findings publicly available. A status report on this effort will be provided at the 2006 Interim Meeting. (Res. 428, A-06)

D-440.961 Establishment of a Network of State Immunization Registries

Our AMA will work with the Centers for Disease Control and Prevention, the Department of Health and Human Services, the Public Health Service and other interested organizations to develop a network of state-based immunization registries that meet a set of minimum standards and allow for access at a national level, while ensuring the protection of the patient-physician relationship. (Sub. Res. 709, I-05)

D-440.962 Avian Influenza Preparedness for Guam and Other Border States and Territories

Our AMA will (1) lobby the Administration to ensure that the Centers for Disease Control and Prevention (CDC), other federal

agencies and the World Health Organization (WHO) assist Guam with the necessary testing kits and other tools necessary for Guam to detect and contain Avian Influenza; and (2) assist other areas of the US to be considered as "border states or territories" for surveillance of this Avian Influenza from Asia, so that the CDC, other federal agencies and WHO may prioritize their resources to detect and contain this virus. (Res. 722, I-05)

D-440.963 Promoting Four Principles of Hand Awareness

Our AMA will advocate that the Centers for Disease Control and Prevention, the Department of Health and Human Services, the National Environmental Health Association and the Society of Healthcare Epidemiology of America collaborate to use the Four Principles of Hand Awareness, as delineated in AMA Policy H-440.894, as a social marketing tool so that the public hears a consistent, scientifically valid message to help prevent the spread of infectious disease, to benefit the public's health. (Res. 702, I-05)

D-440.964 Flu Vaccine Supply

Our AMA will urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis. (Res. 517, A-05)

D-440.965 Avian and Other Influenza Pandemic

(1) Our AMA will: (a) strive to increase the number of people vaccinated annually against influenza, particularly high risk patients, by working with appropriate stakeholders to expand understanding among physicians and patients about who is included in the "high risk" population; and (b) in order to prepare for a potential influenza pandemic, lobby Congress and the Administration to ensure that appropriate funding is provided to the Centers for Disease Control and Prevention, the National Institutes of Health, and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people.

(2) AMA policy is that health care professionals and first responders will be the first line of defense in combating the effects of an influenza pandemic, that the involved national and state agencies (such as the Centers for Disease Control and Prevention, National Institutes of Health and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and our AMA will encourage that these agencies publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers. (Res. 514, A-05; Appended: Res. 530, A-06)

D-440.966 United States Bone and Joint Decade

Our AMA will support enhanced educational efforts of the public and health care providers regarding the development and maintenance of bone health, as well as the prevention and early detection of osteoporosis. (Res. 527, A-05)

D-440.967 Influenza Immunization for Health Care Workers

Our AMA will work to ensure that hospitals and skilled nursing facilities have a system for measuring and maximizing the rate of influenza immunization for health care workers. (Res. 518, A-05; Reaffirmed in lieu of Res. 813, I-06)

D-440.968 Expedited Partner Therapy (Patient-Delivered Partner Therapy)

Our AMA will:

(1) continue to work with the Centers for Disease Control and Prevention as it prepares its "white paper" on expedited partner therapy (EPT) and its follow-up guidance on the implementation of EPT;

(2) review and then support, as appropriate, the final documents on expedited partner therapy as issued by the CDC;

(3) encourage continued research into benefits and potential adverse outcomes that might be associated with the use of EPT to treat sex partners of those diagnosed with either chlamydial or gonorrheal infections; and

(4) continue to work with the CDC as it implements EPT, such as through the development of tools for local health departments and health care professionals to facilitate the appropriate use of this therapy. (CSA Rep. 9, A-05; Appended: CSAPH Rep. 7, A-06)

D-440.969 Protect Children from Skin Cancer

Our AMA will:

(1) support the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR §1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; and

(2) urge the Food and Drug Administration's Center For Devices and Radiological Health to hold a fair hearing as soon as possible on the safety and efficacy of UVA bulbs, as used in indoor tanning facilities. (Res. 440, A-05)

D-440.970 Federal Financing of Poison Center Network

Our AMA will review the Institute of Medicine recommendations for the future of the nation's network of poison centers, take appropriate action, and provide an informational report to the House of Delegates. (Res. 423, A-05)

D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity

Our AMA will:

(1) work with the Centers for Disease Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a disease, using a systematic, evidence-based approach;

(2) continue to actively pursue measures to treat obesity as an urgent chronic condition, raise the public's awareness of the significance of obesity and its related disorders, and encourage health industries to make appropriate care available for the prevention and treatment of obese patients, as well as those who have co-morbid disorders;

(3) encourage physicians to incorporate body mass index (BMI) and waist circumference as a component measurement in the routine adult physical examination, and BMI percentiles in children recognizing ethnic sensitivities and its relationship to stature, and the need to implement appropriate treatment or preventive measures;

(4) promote use of our *Roadmaps for Clinical Practice: Assessment and Management of Adult Obesity* primer in physician education and the clinical management of adult obesity;

(5) develop a school health advocacy agenda that includes funding for school health programs, physical education and physical activity with limits on declining participation, alternative policies for vending machines that promote healthier diets, and standards for healthy a la carte meal offerings. Our AMA will work with a broad partnership to implement this agenda; and

(6) collaborate with the CDC, the Department of Education, and other appropriate agencies and organizations to consider the feasibility of convening school health education, nutrition, and exercise representatives, parents, teachers and education organizations, as well as other national experts to review existing frameworks for school health, identify basic tenets for promoting school nutrition and physical activity (using a coordinated school health model), and create recommendations for a certificate program to recognize schools that meet a minimum of the tenants. (CSA Rep. 4, A-05; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 1, A-08)

D-440.972 Safety for Americans from Nuclear Weapons Testing Act

Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed. (Res. 436, A-05)

D-440.973 Influenza Vaccine Orders from Physicians (MDs and DOs)

Our AMA will immediately take action through the federal government to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine. (Res. 714, I-04; Reaffirmation A-05)

D-440.974 United States Influenza Vaccine Supply: Update and Future Directions for Adult Immunization

Our AMA will (1) work with its partners in immunization and other appropriate stakeholders, such as those in the National Influenza Vaccine Summit, to develop recommendations on the best methods for achieving a strong adult and adolescent immunization program in the United States; and (2) continue its collaboration with the Centers for Disease Control and Prevention and other stakeholders in

influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2010, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply. (BOT Rep. 28, I-04; Reaffirmation A-05)

D-440.975 Support Efforts to Educate Health Care Providers and the Public about Meningococcal Disease and Vaccine

Our AMA will continue to work with the CDC in educating physicians and other health care providers on the importance of informing parents and the public about the meningococcal disease and the availability of a vaccine. (Res. 515, A-04)

D-440.976 Vaccine Safety

Our AMA will (1) continue to work with the federal government and other key stakeholders to monitor the issue of vaccine safety, including the feasibility of creating a national vaccine safety board, and to take appropriate action where necessary, (2) participate in the National Vaccine Advisory Committee's subcommittee on vaccine safety (currently scheduled to be established in Summer 2004) and the Centers for Disease Control and Prevention's external review on vaccine safety, and (3) continue to work with the federal government and other key stakeholders to monitor and respond strongly against the inappropriate release of pre-publication/preliminary scientific data. (BOT Rep. 14, A-04)

D-440.977 Chronic Wasting Disease

Our AMA will study the health issues associated with chronic wasting disease, including but not limited to, facilities processing both game and non-game animals. (Res. 422, A-04)

D-440.978 Culturally Responsive Dietary and Nutritional Guidelines

Our AMA and its Minority Affairs Consortium will:
(1) encourage the United States Department of Agriculture (USDA) Food Guide Pyramid Reassessment Team to include culturally effective guidelines that include listing an array of ethnic staples and use multicultural symbols to depict serving size in their revised Dietary Guidelines for Americans and Food Guide Pyramid;
(2) seek ways to assist physicians with applying the final USDA Dietary Guidelines for Americans and Food Guide Pyramid in their practices as appropriate; and
(3) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (BOT Rep. 6, A-04)

D-440.979 Public Health Leadership

Our AMA will communicate this policy (see H-440.888) to the governor of every state urging him or her to adopt this policy in selecting the top leadership for each state health department. (Res. 438, A-03)

D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis

Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) provide a progress report on the above efforts to the House of Delegates by the 2004 Annual Meeting. (Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07)

D-440.981 Appropriate Reimbursements and Carve-outs for Vaccines

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; and (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine. (BOT Rep. 20, A-03; Reaffirmation A-07)

D-440.982 Smallpox: A Scientific Update

Our AMA will:

(1) continue to collaborate with the Centers for Disease Control and Prevention (CDC) on educational outreach to physicians and the public regarding not only smallpox itself, but also the Investigational New Drug status of the vaccine and the risks and benefits of smallpox vaccination;

(2) remain engaged with the CDC, the Advisory Committee on Immunization Practices (ACIP), and the Federation on this issue and support a commitment to monitor the current status of smallpox and smallpox vaccination in the world and in the United States. Data on issues such as medical furlough, vaccination site care, and contraindications to vaccination should be monitored, as Phase I of the 2002-2003 Department of Health and Human Services (HHS) smallpox vaccination program progresses, with particular attention to adverse effects and inadvertent vaccinia transmission, and appropriate recommendations developed as necessary;

(3) urge state and county medical associations and medical staffs across the country to take the lead in educating physicians and working with public health officials on the local level to develop and implement the National Smallpox Vaccination Program;

(4) work with the DHHS to ensure that vital federal liability protections are in place prior to the initiation of any smallpox vaccination program;

(5) work with the appropriate authorities to ensure that as the ACIP recommendations are implemented, appropriate mechanisms to deal with the liability issues associated with the adverse events of smallpox vaccination are developed in the event that amore encompassing vaccination program is required;

(6) work with the Department of Health and Human Services as it implements its phase-in plan for pre-event smallpox vaccination to ensure that physicians and the public are informed and educated on the risks and benefits of vaccinia (smallpox) vaccine and that physicians receive the relevant clinical information on the vaccinia (smallpox) vaccine; and

(7) continue to monitor issues on liability and compensation as it pertains to the smallpox vaccination program and work to ensure that such protections are addressed. (CSA Rep. 2, I-02; BOT Action in response to referred for decision Recommendation 2 of CSA Rep. 2, I-02)

D-440.983 Cost-Effective Flu Vaccine/Medicare Reimbursement Level

Our AMA shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations. (Res. 503, A-02; Reaffirmation A-05)

D-440.984 Medical Society Public Health Committees

Our AMA: (1) in order to foster a greater understanding and collaboration between the practice of public health and the clinical practice of medicine, particularly in this time of national crisis, and to increase awareness of and participation of clinical practitioners in public health issues, encourages local, state and specialty medical societies to form public health committees within their respective societies, when practical; and (2) shall report the number of state, local and specialty societies with active public health committees to the House of Delegates at the 2003 Annual Meeting. (Res. 422, A-02)

D-440.985 Health Care Payment for Undocumented Persons

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (Res. 148, A-02; Reaffirmation A-07)

D-440.986 Appropriate Reimbursements and Carve-Outs for Vaccines

Our AMA shall use all possible means to pursue adequate reimbursements and carve-outs for vaccines and their administration from all payers with a report back at the 2002 Interim Meeting. (Res. 104, A-02)

D-440.987 Urgent National Vaccination for Smallpox

Our AMA: (1) will encourage federal health authorities to evaluate the risks and benefits of pre-exposure vaccination of the US population for smallpox and to continue planning for mass vaccination of the population if determined to be necessary; (2) Board of Trustees ensure that physicians are routinely updated on smallpox-related issues through the AMA's communication tools, that a report be prepared for the 2002 Annual Meeting on the status of federal planning efforts, and that a report on scientific matters be prepared for the 2002 Interim Meeting; and (3) will endorse and recognize the actions taken so far by President George W. Bush and Secretary of the Department of Health and Human Services, Tommy Thompson, the Centers for Disease Control and Prevention, and the National Institutes of Health to procure smallpox vaccines for the population of the United States. (Res. 410, I-01)

D-440.988 Bolstering Public Health Preparedness

Our AMA will communicate to Congress, the National Association of Local Boards of Health, and chief elected officials at state and local levels, the importance of effective public health agencies and the role that Boards of Health can play in assuring public health protections and effective response to public health emergencies. (Sub. Res. 407, I-01)

D-440.989 Influenza Vaccine

Our AMA will: (1) work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; and (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year. (Res. 414, I-01)

D-440.990 Influenza Vaccine Delays and the 2001-2002 Influenza Season: Update

(1) Our AMA will continue to work with the Centers for Disease Control and Prevention, other federal agencies, and other stakeholders involved in the production, distribution, and administration of influenza vaccine to: (a) resolve the specific problems (i.e., distributors engaging in price inflation, mass vaccinators who do not comply with Advisory Committee on Immunization Practices [ACIP] recommendations, and inadequate Medicare/Medicaid reimbursement) identified in the implementation of the current plan to address influenza vaccine delays in 2001-2002; and (b) address the long-term goal of adequate vaccine supplies to meet Healthy People 2010 goals which will include increasing the industrial base for vaccine production and expanding the current limited protection from liability for both manufacturers and those that administer vaccines. (2) Our AMA Board of Trustees will report back to the House of Delegates at the 2002 Annual Meeting regarding the current status of our AMA's activities to address issues of price instability, vaccine availability, and liability related to the flu vaccine. (BOT Rep. 28, I-01; Reaffirmation I-04; Reaffirmation A-05)

D-440.991 Antimicrobial Use and Resistance

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

D-440.992 Production and Distribution of the Influenza Vaccine: Delays and Shortages

Our AMA: (1) will continue to work with the Centers for Disease Control and Prevention (CDC) to organize, when possible, a second Roundtable meeting of influenza vaccine stakeholders, to assess the current influenza vaccine season and to develop a contingency plan to be implemented in the event of another problem in vaccine production or distribution;

(2) will communicate current ACIP recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available;

(3) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States;

(4) will support mechanisms to increase influenza vaccine supply and vaccine demand among physicians, other providers, and consumers to ensure the goals of Healthy People 2010 are achieved; and

(5) Board of Trustees will immediately investigate issues, including cost, reimbursement, availability, and distribution, which may adversely affect the ability of physicians to provide influenza vaccine to their patients in the upcoming (2001-2002) influenza season. (BOT Rep. 36, A-01; Reaffirmation I-04; Reaffirmation A-05)

D-440.993 Influenza Vaccine Availability And Distribution

Our AMA: (1) will demand a Congressional investigation of the maldistribution and unjustified price increases associated with the year 2000 flu vaccine;

(2) will urge physicians and their patients to write their Congressional representatives in support of an investigation of the 2000 experience with influenza vaccine distribution and pricing;

(3) will explore options for the appropriate oversight of the supply, distribution and marketing of flu vaccines by appropriate agencies within the US Department of Health and Human Services;

(4) and the Federation work with local public health officers through state and county medical societies to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and

(5) will report back to the House of Delegates on efforts to ensure appropriate distribution of influenza vaccines at the 2001 Annual Meeting. (Sub. Res. 416, I-00; Reaffirmation I-04)

D-440.994 Study on the Possible Use of Pneumococcal Vaccine for Chronic Smokers

Our AMA will recommend a study of the possible use of polyvalent pneumococcal vaccine for chronic smokers as a high risk population. (Res. 521, A-00)

D-440.995 Screening Nonimmigrant Visitors to the United States For Tuberculosis

Our AMA encourages the CDC to: (1) study the epidemiology of TB within the nonimmigrant foreign-born population who reside in the United States for longer than 6 months; (2) consider the feasibility of TB screening for nonimmigrant visitors originating from high-risk TB countries who intend to reside in the United States for longer than 6 consecutive months, should data from the studies recommended in 2(a) indicate a need; and (3) consider decreasing the validity period of a TB screening for immigrants from 1 year to 6 months. (CSA Rep. 1, I-99)

D-440.996 Sharps Disposal

Our AMA will develop guidelines that physicians can distribute to patients on the proper disposal of sharps used at home. (Res. 404, A-99)

D-440.997 Support for Public Health

Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members' patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass. (Res. 409, A-99; Modified CLRPD Rep. 1, A-03)

D-440.999 Chemical Analysis Report of Public and Commercial Water

Our AMA: (1) requests the appropriate federal agency to require analysis and appropriate labeling of the chemical content of commercially bottled water as well as of the water supplies of cities or towns; and (2) will work with the American Dental Association to promote the availability of fluoridated, commercially bottled water to consumers. (Res. 427, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

D-445.000 Public Relations

D-445.998 Confusion Regarding Use of the Term "Doctor"

Our AMA will strongly encourage the media to require that the actual degree be affixed to the name of all who endorse health-related products. (Res. 605, A-05)

D-445.999 Assessment of the AMA Appearance Program

(1) A Representation Program Advisory Team (RPAT), co-chaired by the Senior Vice President (SVP) for Governance and Operations and the SVP for Communications, was established. This team, made up of senior staff appointed by the EVP, developed recommendations for consideration by the Board Chair. The Team will meet at least monthly to review data collected on the program and provide feedback to the Chair. To date this team has:
(a) Recommended goals for an AMA Representation Program that includes the current AMA Representation Program aligned with priorities set by the AMA Board at its annual planning session in February 2001. These goals include annual and biannual objectives to start with the term of the new Board Chair.
(b) Identified key groups or audiences where interaction with these entities would further these objectives. The priorities established with the Board would be primary considerations for assignments made by the Chair.
(c) Developed strategies for seeking appearance opportunities to these entities. This includes identification of potentials for secondary visits and consideration of using staff in lieu of trustees where appropriate. An approved template is a primary consideration by the Chair in making trustee assignments or approving staff substitutions recommended by the EVP.
(d) Established criteria for providing feedback to the Board on the effectiveness of the program, including an evaluation feedback mechanism from the entity visited.
(e) Activity considering a change to the name of the program.

(2) The AMA representation program will involve members of the sections located in the geographic area of the appearance whenever

possible to increase outreach to the AMA members and potential AMA members represented by the sections. (BOT Rep. 20, A-01; Modified CLPRD Rep. 1, A-03)

D-450.000 Quality of Care

D-450.970 Medical Care Outside the United States

Our AMA will advocate the development of model state legislation which encompasses our nine AMA principles above and which can be used to regulate insurance companies and any other business that refers patients for non-local care. (CMS Rep. 1, A-08)

D-450.971 Evaluating the Physician Quality Reporting Initiative

Through its committee structure, our AMA will examine and evaluate the implementation and data relating to the Physicians Quality Reporting Initiative and report back to the House of Delegates at the 2008 Interim Meeting on compliance of the program with AMA Principles and Guidelines on Pay-for-Performance as well as any benefits, unintended consequences and negative effects for patients and physicians. (Res. 705, A-08)

D-450.972 Empowering Patients, Improving Quality

Our AMA will request that the Physician Consortium for Performance Improvement® consider expanding its focus to include the development and distribution of educational materials to patients relevant to specific measures (and/or measure topics) and to encourage the use of these materials within the context of the physician-patient relationship. (Res. 528, A-07)

D-450.973 Certification and Accreditation Programs for Disease-Specific Care

Our AMA will: (1) encourage The Joint Commission to continue to work with the AMA-convened Physician Consortium for Performance Improvement ® (Consortium) to develop or use performance measures that involve physician practice for all of the Disease-Specific Certification programs; and (2) encourage the National Committee for Quality Assurance to work with the Consortium to develop performance measures for Disease-Specific care for use in physician practices. (BOT Rep. 7, A-07)

D-450.974 Ambulatory Care Quality Alliance

Our AMA: (1) will advocate that the Ambulatory Care Quality Alliance (AQA) establish a fair and open process for conducting its business through bylaws, due process, representative voting and respect for alternate viewpoints; and (2) request that the AQA avoid a rapid development and implementation of its agenda to ensure that adequate time and consideration is allowed to evaluate and endorse performance measures that serve patients within the framework of the AMA's Principles and Guidelines on Pay-for-Performance and public reporting. (Res. 810, I-06)

D-450.975 Centers of Excellence Designation

Our AMA will: (1) work with appropriate organizations such as the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, America's Health Insurance Plans, the American Hospital Association, and others to assure the development of quality-based criteria which must be met before a program can be designated a "Center of Excellence"; and (2) inform and require from all health insurance carriers and companies, including CMS, that any designation of "Center of Excellence" status be based on quality outcomes and not to require that physician insurance participation be part of those requirements. (Res. 528, A-06)

D-450.976 Patient Safety

Our AMA will:
(1) monitor the data collection process of the Patient Safety Organizations and other reporting systems;
(2) evaluate the results regarding the scope and issues surrounding patient safety events; and
(3) prepare a report on the findings when these data are made available. (Sub. Res. 517, A-06)

D-450.977 Patient Adherence to Treatment Plans

Our AMA will compile and make available a list of existing resources and tools that have been developed to assist physicians and patients in optimizing patient adherence. (Res. 505, A-06)

D-450.978 Physician Consortium for Performance Improvement; Unfunded Performance Improvement Projects

Our AMA will:
(1) continue to expand the Physician Consortium for Performance Improvement (Consortium), inviting all medical societies in the

AMA House of Delegates to participate;
(2) continue to promote the Consortium as the leading resource for performance measures development and maintenance;
(3) continue to advocate for appropriate implementation of performance measures;
(4) continue to encourage the testing and evaluation of Consortium measures by appropriate entities;
(5) continue to communicate organized medicine's strong objections to implementation of mandatory, unfunded performance improvement projects and offer our assistance to rectify deficiencies in these programs;
(6) continue to promote the AMA guidelines that provide operational boundaries that can be applied to specific components of pay-for-performance programs; and
(7) monitor the newly established National Quality Forum, a merger of the National Quality Forum and the National Committee for Quality Health Care, to determine its current and future scope. (BOT Rep. 21, A-06; Reaffirmation A-07)

D-450.979 Post-Discharge Test Results

1. Our AMA will alert organized medical staffs of the results of the study, "Improving Patient Care: Patient Safety Concerns Arising from Test Results that Return after Hospital Discharge," published in the July 19, 2005, issue of the *Annals of Internal Medicine*, which shows that many patients are discharged from hospitals with tests pending and physicians are often unaware of the potentially actionable tests results returning post-discharge and urges the medical staffs to develop processes for addressing the issue.

2. Our AMA Board of Trustees will work with the American Hospital Association to develop a joint statement about the importance of coordinating post-discharge care and forwarding test results to the patient's primary care physician and, if different, the physician assuming care for a patient after hospital discharge. (Res. 732, A-06)

D-450.980 Physician Time Spent with Patients and with Hospital Documentation

Our AMA will:

(1) advocate for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures;

(2) continue to work with accrediting bodies and government agencies to substantially reduce hospital paperwork; and

(3) continue to work with electronic health record (EHR) system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine. (BOT Action in response to referred for decision Res. 511, A-03)

D-450.981 Protecting Patients Rights

Our AMA will:

(1) continue to advocate for the repeal of the flawed sustainable growth rate formula without compromising our AMA's principles for pay-for-performance;

(2) develop a media campaign and public education materials to teach patients and other stakeholders about the potential risks and liabilities of pay-for-performance programs, especially those that are not consistent with AMA policies, principles, and guidelines; and

(3) provide a report back to the House of Delegates at its 2006 Annual Meeting. (Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-06; Reaffirmation A-07)

D-450.982 Medicare Physician Voluntary Reporting Program

Our AMA will (1) continue to communicate its strong objections to CMS's Physician Voluntary Reporting Program; and (2) work with other Federation organizations to express organized medicine's strong concerns on the proposed implementation of the Physician Voluntary Reporting Program and to offer its assistance to rectify deficiencies in the program. (BOT Rep. 19, I-05)

D-450.983 Expansion of Scope of Activities of AMA Physician Consortium for Performance Improvement

Our AMA Board of Trustees will (1) expand the AMA Physician Consortium for Performance Improvement (Consortium) to include representatives from all national medical specialty societies and state medical societies who wish to participate; (2) expand the scope of the Consortium to include development of clinical performance measures, validation of clinical performance measures, and direction on appropriate implementation of clinical performance measures; and (3) study and prepare a report to clarify the role and authority of the National Quality Forum and identify pathways that may allow the Consortium and physicians to have greater

influence in the validation of clinical performance measures. (Res. 601, I-05)

D-450.984 Physician-to-Physician Communication

Our AMA will continue to be actively engaged in Clinical Quality Improvement activities that address accreditation standards and the Continuity of Care Record, and that involve collaboration with the Institute for Healthcare Improvement. (BOT Rep. 6, A-05)

D-450.985 Health Insurance Company Report Cards

Our AMA will: (1) develop a model health insurance company report card which measures, at a minimum, performance standards for patient satisfaction, physician satisfaction, hospital satisfaction, use of rapid electronic payment, and medical loss ratio; and (2) encourage state medical societies to use this template to produce local or statewide report cards. (Res. 735, A-05)

D-450.986 Evidence-Based Medicine

Our AMA: (1) working with state medical associations, specialty societies, and other medical organizations, will educate the Centers for Medicare and Medicaid Services, state legislatures, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, will work with other medical organizations to develop model state legislation to protect the physician-patient relationship from cost-based medicine policies inappropriately characterized as "evidence-based medicine" and to disseminate the measure to state medical associations through the Advocacy Resource Center. (Res. 704, A-05)

D-450.987 Support of Patient Safety Aspects of JCAHO

Our AMA will continue to work with the Joint Commission on Accreditation of Healthcare Organizations on the development of standards which improve patient safety; and our AMA and JCAHO will then present these changes to the Centers for Medicare and Medicaid Services to effect an update of good health care policy and to delete outdated wasteful health care policy. (Res. 530, A-04)

D-450.988 Performance Measures for Evidence-Based Medicine

Our AMA will continue to ensure the quality of medical care through the appropriate use of evidence-based clinical performance measures. (Res. 506, A-04)

D-450.989 Office-Based Surgery Regulation

Due to existing urgency, our American Medical Association convene together with the American College of Surgeons, by February 1, 2003, a work group of interested specialty societies and state medical associations, with the input of recognized accrediting bodies, to identify specific requirements for optimal office-based surgery/procedures in those situations where moderate sedation/analgesia, deep sedation/analgesia or general anesthesia (as defined by the American Society of Anesthesiologists) may be administered; and utilize those requirements to develop guidelines and model state legislation for use by state regulatory authorities to assure quality of office-based surgery/procedures, with a report back to the House of Delegates at the 2003 Interim Meeting (Sub. Res. 708, I-02)

D-450.990 Crossing the Quality Chasm: A New Health System for the 21st Century -- An American Medical Association Response

Our AMA: (1) work to ensure that physicians take a leadership role in any patient safety initiative; (2) and the Federation participate actively with the Agency for Healthcare Research and Quality (AHRQ) and other Federal agencies and private sector organizations in initiatives that respond to the IOM report, Crossing the Quality Chasm, and its recommendations; and (3) identify a mechanism for informing the public of our role in patient safety. (BOT Rep. 14, I-02)

D-450.991 Quality Improvement Projects and Human Subjects Research

(1) Our AMA will seek to ensure an active role in the series of meetings and the deliberate process proposed by The Hastings Center to develop a framework for addressing the quality improvement/research issues.

(2) Our AMA will continue to research this topic, particularly by reviewing forthcoming publications, corresponding with experts in the field, and completing a more detailed review of the framework developed by the Oversight Body for the Ethical Force Program, to prepare a supplemental report as relevant information becomes available. (CSA Rep. 3, I-02)

D-450.992 Institute of Medicine Report on "Crossing the Quality Chasm"

Our AMA shall: (1) develop a position on the impact of the Institute of Medicine report on "Crossing the Quality Chasm" on

physicians and health care delivery systems; (2) provide guidance to physicians, subspecialty organizations and health care delivery systems on the response to the IOM report and (3) study the IOM report "Crossing the Quality Chasm," and report back to the House of Delegates at the 2002 Interim Meeting. (Res. 808, A-02)

D-450.993 Preventing Needlestick Injuries Among Front Line Health Care Workers

Our AMA shall: (1) undertake an initiative that health care workers at hospitals, doctor's offices and other facilities be encouraged to use safety-engineered devices and needle-less systems for both injecting drugs and drawing blood, when, in the physician's experience and judgement, it is deemed practicable; (2) communicate a synopsis of the provisions of the Needlestick Safety and Prevention Act to physicians through publication in appropriate AMA communications vehicles; and (3) send a copy of this resolution to the American Hospital Association. (Res. 414, A-02)

D-450.995 Revise National Practitioner Data Bank Criteria

In medical malpractice cases, Our AMA will act to modify and change the criteria on which a physician is listed in the National Practitioner Data Bank. (Res. 809, I-99)

D-450.996 American Medical Accreditation Program (AMAP)

(1) Beginning with the 1999 Interim Meeting, the House of Delegates may establish policy on professional standards for physician performance and quality measurement, consistent with current House of Delegates roles with other accreditation organizations, such as JCAHO and ACGME. Our AMA will request that its representatives seek incorporation of those policies into the standards and processes of AMAP.

(2) Our Board of Trustees report back to the House of Delegates at the 2000 Annual Meeting

(3) AMAP will continue aggressively to develop performance and outcomes measurement instruments;

(4) Our AMA Board of Trustees will present a clear and detailed business strategy and make available for perusal the business plan for AMAP at A-2000;

(5) Our AMA/AMAP will continue its present business endeavors, expend budgeted money judiciously to develop both its strategic and business plans, and pursue other ventures to better position AMAP for evaluation by the House of Delegates at A-2000;

(6) Our AMA Board of Trustees will continue to exercise its fiduciary oversight of AMAP activities. (BOT Rep. 26, I-99)

D-450.997 AMA Quality Care Alert

Consideration of an AMA "Quality Care Alert" on the "overuse and misuse of antibiotics" undergo the same process by which prospective topics for "Alert" are identified. (Sub. Res. 829, A-99)

D-450.998 Addressing the Disruptive Physician

1. Our AMA will: (a) identify and study behavior by physicians that is disruptive to high quality patient care, and (b) define the term "disruptive physician" and disseminate guidelines for managing the disruptive physician.

2. Our AMA: (a) will work with The Joint Commission and other interested parties to develop a definition of disruptive behavior by a physician to include the actions that would rise to the level of true abusive behavior; (b) will work with The Joint Commission and other interested parties to include rules for an appeals process that comply with due process for physicians accused of disruptive behavior; (c) will work to ensure that allegations of disruptive behavior by physicians will be handled by the organized medical staff through its established bylaws; and (d) Board of Trustees will request that the Council on Ethical and Judicial Affairs update Policy E-9.045, Physicians with Disruptive Behavior. (Res. 9, A-99; Res. 1, I-08)

D-455.000 Radiation and Radiology
(See also: Environmental Health; Public Health)

D-455.995 Imaging Safety and Standardization

Our AMA will continue to promote and fund its successful work on the promotion of interoperability and use of imaging data and presentation to improve patient safety for the next 18 months, convening key industry and specialty providers to adopt this groundbreaking accomplishment; and the results of the initiative to promote the interoperability and use of imaging data and presentation to improve patient safety will be reported back to the House of Delegates by the 2009 Interim Meeting, or sooner if goals

are met prior to the 2009 Annual Meeting. (Res. 523, A-08)

D-455.996 Development of Standards for MRI Equipment and Interpretation to Improve Patient Safety

1. Our AMA will convene a meeting of medical stakeholders to identify optimal approaches for magnetic resonance imaging (MRI) standardization that would serve clinical needs. Invitees will include representatives from the following medical specialty societies: American Association of Neurological Surgeons; American Congress of Neurosurgery; American Academy of Neurology; American College of Radiology; American Academy of Orthopaedic Surgeons; American College of Cardiology; American Academy of Ophthalmology; American Academy of Otolaryngology – Head and Neck Surgery Foundation.

2. Once optimal approaches that serve clinical needs have been identified, our AMA will convene a joint meeting of medical and other stakeholders, e.g., payers, vendor standardization organizations, accreditators, and major MRI manufacturers that would be impacted by MRI standardization. Invitees will include representatives from the following organizations: Centers for Medicare and Medicaid Services/other payers; National Electrical Manufacturers Association (NEMA); Digital Imaging and Communications in Medicine Standards Committee of NEMA; Intersocietal Commission for the Accreditation of MRI Laboratories; Intersocietal Accreditation Commission; Institute for Magnetic Resonance Safety, Education, and Research; GE; Siemens; Philips; Toshiba; Hitachi; and FONAR.

3. Our AMA will recommend that stakeholders agree to a voluntary system of MRI standardization and accreditation, and focus on developing solutions across professional, payer, and industry partners that promote interoperability and use of MRI data and presentation and will urge the development of a timetable that would result in 50% interoperatibility within one year.

4. If voluntary efforts fail and/or vendors and others are reticent to act, our AMA will advocate for mandated change through legislative channels. (BOT Rep. 30, A-07)

D-455.997 Development of Standards for MRI Equipment and Interpretation to Improve Patient Safety

Our AMA will convene a meeting(s) with representatives from magnetic resonance imaging manufacturers, radiology and other interested medical specialties, and imaging facilities, with the goals of: (1) agreeing to standards in electronic imaging formats (e.g., left to right, axial, coronal, sagittal); (2) developing standards of data manipulation and localization consistent throughout all units for best interpretation of the data; and (3) ensuring that each electronic format is equipped with the capability of loading and launching its contained images on the physician's computer; and a report of the meeting(s) will be issued to the House of Delegates at the 2007 Annual Meeting. (Res. 539, A-06)

D-455.998 Ionizing Radiation Exposure in the Medical Setting

Our AMA will: (1) collaborate with appropriate specialty medical societies and other interested stakeholders to convene a meeting (a) to examine the feasibility of monitoring and quantifying the cumulative radiation exposure sustained by individual patients in medical settings; and (b) to discuss methods to educate physicians and the public on the appropriate use and risks of low linear energy transfer radiation in order to reduce unnecessary patient exposure in the medical setting; and (2) continue to monitor the National Academy of Sciences' ongoing efforts to study the impact of low levels of low linear energy transfer radiation on human health. (CSAPH Rep. 2, A-06)

D-455.999 Radiation Exposure

Our AMA will work with the public health, radiology and radiation oncology specialty societies and all other interested parties to study the issue of radiation exposure by the American public and develop a plan, if appropriate, to allow the ongoing monitoring and quantification of radiation exposure sustained by individual patients in medical settings. (Res. 521, A-05)

D-460.000 Research

D-460.975 Tobacco Use or Exposure as a Variable in Clinical Research

Our AMA urges clinical investigators to carefully consider the need to include an assessment of smoking status, smoking history, and exposure to secondhand smoke in the design of clinical trial protocols and analysis of patient outcomes. (BOT Rep. 9, I-06)

D-460.976 Genomic and Molecular-based Personalized Health Care

Our AMA will:

(1) continue to recognize the need for possible adaptation of the US health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized

informatics tools to develop individual risk assessments and personal health plans;
(2) support studies aimed at determining the viability of prospective care models and measures that will assist in creating a stronger focus on prospective care in the US health care system;
(3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing;
(4) maintain a visible presence in genetics and molecular medicine, including web-based resources and the development of educational materials, to assist in educating physicians about relevant clinical practice issues related to genomics as they develop; and
(5) promote the appropriate use of pharmacogenomics in drug development and clinical trials. (CSAPH Rep. 4, A-06)

D-460.977 NIH Public Access Policy

Our AMA will: (1) continue to work with publishing and professional organizations, and continue to work with Congress to prevent any changes to the current policy that requires public release of NIH research articles within 12 months of publication; and (2) continue to advocate that free content be accessed at the AMA's online journal web sites, rather than at a government site, to preserve our brand and to promote use of other AMA resources. (BOT Rep. 36, A-06)

D-460.978 Department of Veterans Affairs Research Funding

Our AMA will: (1) encourage the Department of Veterans Affairs (DVA) to provide adequate levels of support for health care research funding and special projects; (2) encourage implementation of the Policy Board's recommendation on Veterans Equitable Resource Allocation (VERA) Research Support to assure that the clinicians conducting the research have appropriate levels of support; and (3) inform the DVA that it will monitor the effect the Policy Board's recommendation has on veterans health care research. (BOT Action in response to referred for decision Res. 504, A-00)

D-460.979 Physicians and Clinical Trials

Our AMA will (1) work with the Pharmaceutical Research and Manufacturers of America, the American Academy of Pharmaceutical Physicians, and all other appropriate organizations to develop guidelines that would eliminate the use of restrictive covenants or clauses that interfere with scientific communication in agreements between pharmaceutical companies or manufacturers of medical instruments, equipment and devices, and physician researchers; and (2) take all appropriate action to protect the rights of physician researchers to present, publish and disseminate data from clinical trials. (Res. 610, I-04)

D-460.980 Scientific Integrity

Our AMA will insist that the federal government rely on sound medical science in formulating public health policies. (Res. 533, A-04)

D-460.981 Support for Federally-Funded Medical Research

Our AMA will call for an increase in 2005 appropriations for NIH and the Agency for Healthcare Research and Quality sufficient to allow the US to take advantage of the recently completed campaign to double the nation's investment in biomedical research. (Sub. Res. 521, A-04)

D-460.982 AMA Advocacy for Federal Funding on the Ethical, Legal, and Social Implications (ELSI) of Bioterrorism Preparedness and Research

Our AMA will advocate that a portion of federal funding for bioterrorism preparedness programs and activities be dedicated for research on the ethical, legal, and social implications of bioterrorism preparedness and research. (Res. 9, A-04)

D-460.983 Translating Biomedical Research to the Bedside

Our AMA will: (1) give high priority to bringing promising biomedical research to the bedside;

(2) advocate for the elimination of unreasonable barriers to bedside care using new research;

(3) work with specialty societies, the American Association for the Advancement of Science, the Institute of Medicine's Clinical Research Roundtable, appropriate federal agencies, and other organizations to develop practical measures to expedite the incorporation of scientific advances into medical practice;

(4) alert the President and Congress regarding health problems not adequately addressed due to lack of support for fast-tracking clinical research to bedside applications; and

(5) report back on actions taken to implement this resolution at the 2004 Annual Meeting. (Res. 812, I-03)

D-460.984 Support of the National Institutes of Health Peer Review System

Our AMA will: (1) inform Congress of its strong support for the National Institutes of Health peer review system and its deep concern regarding apparent efforts to breach the integrity of the system; and (2) communicate directly with the Department of Health and Human Services, Secretary Tommy Thompson, the leaders of Congress in the Senate and House of Representatives its strong support for the National Institutes of Health peer review. (Res. 725, I-03)

D-460.985 Incidence of Autism, Asperger's and Other Pervasive Developmental Disorders

Our AMA will work with the Centers for Disease Control and Prevention (CDC) and other appropriate medical specialty societies to study the reported increase in incidence of autism, Asperger's and other pervasive developmental disorders, and to specifically evaluate the population-based data on this issue currently being generated by the CDC. (Sub Res. 503, A-03; Reaffirmed in lieu of Res. 535, A-06)

D-460.986 Commercialized Medical Screening

Our AMA will urge government funding agencies to continue to fund well-designed, large-scale clinical trials aimed at determining the safety, value, and cost-effectiveness of screening imaging procedures (CSA Rep. 10, A-03)

D-460.987 End State Renal Disease (ESRD) Networks Quality Improvement Projects

(1) Our AMA calls upon: (a) The Office of Human Research Protections to develop clear guidelines to differentiate between quality improvement and human subjects research; (b) The Centers for Medicare & Medicaid Services develop a process to ensure that all Quality Improvement Projects (QIPs) and other studies performed by the End Stage Renal Disease Networks and other CMS contracted Quality Improvement Organizations are reviewed and certified as exempt studies under the federal regulations covering human subjects research protection; and (c) The Centers for Medicare & Medicaid Services to indemnify the volunteer members of the Medical Review Boards from responsibility for having participated in QIPs developed in accordance with CMS instructions that were not in compliance with federal regulations covering human subjects research protection. (2) Our AMA shall study the issue of the relationship between quality improvement projects and human subjects research and the potential impact defining of quality improvement projects as human subjects research on improving the quality of medical care by and within the private sector and issue a report at the 2002 Interim Meeting. (Res. 807, A-02)

D-460.988 Payment of Routine Care for Clinical Trial Participants

Our AMA shall continue to strongly advocate for the enactment of federal legislation consistent with AMA policies related to the payment of clinical trials, including the routine care of trial participants. (CMS Rep. 4, A-02)

D-460.989 Appropriate Specialty Representation on Integrated Review Groups of the National Institutes of Health

Our AMA will encourage the National Institutes of Health to ensure appropriate specialty representation on Integrated Review Groups reviewing grants relevant to that specialty. (Sub. Res. 502, A-00)

D-460.990 Science, Policy Implications, and Current AMA Position Regarding Embryonic/Pluripotent Stem Cell Research and Funding

Our AMA shall continue to monitor PSC research and update AMA policies as required with reference to advances in this field (CSA Rep. 15, I-99)

D-460.991 Interim Report of the Inter-Council Task Force on Privacy and Confidentiality

(1) Our AMA urges the Federal Government to consider augmenting the standards of the Common Rule to state that IRBs may waive or modify the requirement of a researcher to obtain the specific informed consent of a research subject for use of his or her personally identifiable health information only when it can be documented that:
(a) There is no practicable alternative to the use of such personally identifiable health information and that, in any case, such information is de-identified at the earliest practicable opportunity;
(b) The health researcher has fully disclosed which of the personally identifiable health information to be collected or created will be linked to other personally identifiable health information;
(c) If, in the course of the proposed research, such health researcher intends to link personally identifiable health information to other health information or if there is a risk that such information may be linked, appropriate safeguards are employed to protect such information against re-identification or subsequent unauthorized linkage;

(d) The institutional review board shall have the opportunity to review any publication of information based upon the personally identifiable health information collected or created under the provisions of this section to ensure that no disclosures are made which might identify an individual;
(e) At the conclusion of the proposed health research or at some specific date, the health researcher shall destroy all of the data containing personally identifiable health information as well as all copies of such data, but that the institutional review board may extend the date of destruction if the researcher demonstrates a continuing or new need for protected health information for which such researcher would be qualified for a waiver of informed consent in accordance with this section;
(f) The health researcher has presented adequate assurances that none of the data containing protected health information will be given, loaned, sold, disseminated or otherwise disclosed to other parties.
(2) Our AMA encourages medical schools, teaching institutions, and other entities that conduct medical research to assure that their IRBs are afforded adequate personnel and other resources to accomplish their mission "to safeguard the rights and welfare of human research subjects." (BOT Rep. 36, A-99)

D-460.992 Clinical Research in Managed Care

Our AMA will study the degree to which managed care organizations support and participate in clinical research. (Sub. Res. 722, A-99)

D-460.993 Support of Embryonic Stem Cell Research

Our AMA will encourage strong public support of federal funding for research involving human pluripotent stem cells. (Res. 526, A-99)

D-460.994 Decade of the Brain

Our AMA will work with interested national medical specialty societies, as well as the National Institutes of Health and other relevant federal agencies, to review the successes of the Decade of the Brain initiative, summarizing the great advances in brain research and medical practice that can be understood as deriving from our 1990 action to support the launching of the Decade of the Brain initiative. This review be submitted in a report to the House of Delegates at the 2000 Annual Meeting for appropriate publication and dissemination. (Res. 517, A-99)

D-460.995 E-Biomed: A National Institutes of Health Proposal to Publish Biomedical Research Reports on a Single Web Site

Our AMA will: (1) study the implications of the E-biomed proposal from the director of the National Institutes of Health (NIH) for scientific publication in general and for the AMA's journals, as well as possible implications for medical practice; (2) consult with other leading publishers of scientific journals to determine if a consensus can be reached about the implications of E-biomed; and (3) communicate the results of the study of the E-biomed proposal to the director of the NIH. (Res. 533, A-99)

D-460.996 Medical Genetics

Our AMA will join with the American College of Medical Genetics and other professional and lay organizations to: (1) Publicize the resources and services offered by medical genetics professionals to other medical specialties; (2) advocate for federal funding specifically targeted to the development and stable support of a clinical genetics infrastructure commensurate with the application of new genetic knowledge to the prevention and treatment of human disease; and (3) explore appropriate mechanisms for federal support such as: (a) reauthorization of The Genetic Disease Act (PL 94-278), (b) introduction of a new title in the Social Security Act, and (c) other alternatives. (Res. 527, A-99)

D-460.997 Implications of Brain Development Research

Our AMA will support the efforts of the NIH and others to encourage and fund research into : (1) basic human brain development processes and the relationship of these processes to cognitive development; and (2) exploring the relationships among brain development, environmental factors, and cognitive and behavioral disorders and to seek effective mechanisms to prevent and treat these disorders (CSA Rep. 15, A-99)

D-460.998 Cloning and Human Embryo Research

Our AMA will support efforts to convene a conference of scientists, physicians, bioethicists, and other relevant experts to develop consensus on the scientific and bioethical issues raised by somatic cell nuclear transfer technology. (CSA Rep. 7, A-99)

D-460.999 Support for Upgrading and Expanding Medical Research Facilities

Our AMA: (1) will work with other scientific and medical organizations, such as the Association of American Medical Colleges and

the Association of American Universities, in support of legislation and appropriation that would fund modernization and expansion of biomedical research facilities and would authorize funding of expensive shared equipment and instrumentation not normally covered in research grants awarded to individual investigators; and (2) membership be encouraged to support this effort through direct communication with their elected representatives as legislative recommendations are developed. (Res. 319, A-99)

D-470.000 Sports and Physical Fitness

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)

D-470.993 Government to Support Community Exercise Venues

Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. (Res. 423, A-04)

D-470.994 Requirement for Daily Free Play in Schools

Our AMA will work with other interested medical societies to urge the Department of Education and state and national legislatures to enact regulatory and legislative provisions that ensure at least thirty minutes of daily free play for elementary school students. (Res. 409, A-04; Reaffirmation A-07)

D-470.995 Hormone Abuse by Adolescents

Our AMA will: (1) collaborate with the Hormone Foundation, the United States Anti-Doping Agency, the National Institute on Drug Abuse, interested medical specialty societies, and other relevant stakeholders on a nationwide campaign designed to reduce the prevalence of adolescent hormone abuse and to foster the development of healthy behaviors and fair competition; (2) support legislation designed to reclassify anabolic steroid precursors that are currently protected by the Dietary Supplement and Health Education Act as prescription drugs subject to the Controlled Substances Act; and (3) continue to monitor trends in adolescent hormone abuse including the apparent use of growth hormone, recombinant human erythropoietin, and its analogues. (CSA Rep. 9, A-03)

D-470.996 Anabolic/Androgenic Steroid Abuse by Students

Our AMA will call for a coordinated effort by government, academics, and organized medicine to address the problem of the use of anabolic/androgenic steroids by students in the following ways: (1) Assist in convening multidisciplinary meetings to better define the current state of knowledge regarding epidemiology of drug use, safety and efficacy of drugs, technology and application of drug testing. Also included would be safe and efficacious methods to achieve physical fitness and enhance public awareness of these issues in school staff and students.

(2) As a goal of those meetings, identify appropriate research targets to: (i) better define the extent and epidemiology of the problem among both male and female students, (ii) evaluate the safety of anabolic/androgenic steroids in both boys and girls, and (iii) improve technology of drug detection and principles of its application.

(3) Encourage further development of public awareness programs for school staff and students, including reasonable alternatives to steroid drugs.

(4) Seek to identify potential funding for this effort from government, industry, and other private sector sources. (Res. 501, A-01)

D-470.997 Sports Injury Reduction

Our AMA will work with members of the Federation to promote awareness of programs to reduce injuries in contact sports, such as the "Heads Up, Don’t Duck" program for hockey players, among physicians, athletes, coaches, parents and administrators. (Res. 402, A-01)

D-470.998 Cardiovascular Preparticipation Screening of Student Athletes

Our AMA will submit this report to the Preparticipation Physical Evaluation Task Force (comprised of representatives of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine) requesting that American Heart Association recommendations for (a) family history of heart disease; (b) a specific item for recognition of a heart murmur in the physical examination; and (c) a specific item for recognition of the physical stigmata of Marfan syndrome be considered in future iterations of the Preparticipation Physical Evaluation form. (CSA Rep. 5, I-99)

D-470.999 Boxing Injuries

(1) Our AMA will: (a) develop and promote guidelines for adolescent health that include inquiring about participation in boxing, and that promote participation in other individual or team sports;
(b) work with the Surgeon General, AMA Alliance, Brain Injury Association, Brain Trauma Foundation, American Academy of Neurology, American Academy of Ophthalmology, and other interested groups to develop a public campaign to prevent boxing brain and eye injuries;
(c) incorporate these strategies into our AMA's broad initiatives to reduce violence; and
(d) encourage further research into the mechanisms, pathophysiology, prevention, and treatment of boxing brain and eye injuries.

(2) Further long-term outcome data be obtained from amateur boxers, in order to more accurately establish the risks of participation.

(3) This report be widely disseminated to physicians, as well as governmental bodies and various commissions that regulate boxing. (CSA Rep. 3, A-99)

D-475.000 Surgery

D-475.997 Postoperative Care of Surgical Patients

1. Our AMA encourages private payers to make transparent their policies regarding the reporting of physician work that is performed by more than one physician for the performance of a segment (i.e., preoperative, surgical, or postoperative care) of a procedure with an assigned global period.

2. Our AMA strongly encourages the American public to become better informed about the need to coordinate both preoperative and postoperative care, especially in cases where the patient's site of recovery is a significant distance from where the initial surgery was performed. (BOT Action in response to referred for decision CMS Rep. 3, I-06; Modified: CMS Rep. 1, A-08)

D-475.998 Home Sedation for Children Undergoing Outpatient Procedures

Our AMA will work with the American Society of Anesthesiologists, the American Academy of Pediatrics, and other interested specialty societies to publicize existing guidelines on the pre-procedural sedation of children outside of a monitored health care setting. (Res. 805, I-06)

D-475.999 Postoperative Care of Surgical Patients

Our AMA will study the feasibility, cost, ethical issues and mechanisms for reimbursement of physicians for services rendered in the postoperative period (when not delivered by the initial surgical team) including a review of coding rules, payment policies, legal and ethical issues related to co-management and fee splitting, and implementation costs. (Res. 830, I-05)

D-478.000 Technology - Computer

D-478.988 Studying and Supporting Health Information Exchange

Our AMA will: (1) study existing health information exchange pilots, create a report for the 2008 Interim Meeting that specifically outlines the ways in which a health information exchange might be used to maximally benefit physicians and their patients and includes ways in which the AMA might apply its resources to assist in the further study and eventual realization of those benefits; and (2) explore ways to help our members have access to and/or share aggregated practice performance data including claims-based and clinical information. (Res. 722, A-08)

D-478.989 Accuracy of Internet Physician Profiles

Our AMA will investigate: (1) the publication of physician information on Internet Web sites; and (2) potential solutions to erroneous physician information contained on Internet Web sites with report back at the 2008 Interim Meeting. (Res. 612, A-08)

D-478.990 Clinical Information Technology Assistance

Our AMA will seek a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including electronic medical record systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors. (Res. 808, I-07; Reaffirmation I-08)

D-478.991 Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs

Our AMA will: (1) develop contracting guidelines for physicians considering accepting or donating Electronic Medical Records and Electronic Health Records systems (EMRs/EHRs) from or to hospitals and health care systems; (2) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (3) encourage interoperability of information systems used by hospitals and health care facilities. (BOT Rep. 2, I-07)

D-478.992 Health Information Technology Purchasing Guidance

Our AMA will help educate physicians via the AMA web site and appropriate AMA publications about issues to consider when purchasing health information technology (HIT) systems, including ensuring the availability of adequate technical support. (Sub. Res. 712, A-07; Reaffirmation I-08)

D-478.993 Criteria for Assessing the Quality of Health Information on the Internet

Our AMA (1) does not endorse the criteria of the Health Summit Working Group; and (2) will disseminate the AMA Web Guidelines to the Federation in lieu of endorsing the criteria of the Health Summit Working Group. (BOT Action in response to referred for decision Res. 617, I-99)

D-478.994 Health Information Technology

Our AMA will:

(1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);

(2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; and

(3) support initiatives to ensure interoperability among all HIT systems. (Res. 723, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed: Res. 726, A-08; Reaffirmation I-08)

D-478.995 National Health Information Technology

Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. (Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08)

D-478.996 Information Technology Standards and Costs

Our AMA will:
(1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;
(2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;
(3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems;
(4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and
(5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08)

D-478.997 Ownership and Control of Digital Identities

Our AMA will continue to (1) consult with the AMA Electronic Medical Advisory Committee and undertake educational efforts to inform physicians of the importance of protecting the ownership of their individually identifiable information used for authentication in an electronic environment; and (2) work with the appropriate standard developing organizations and other groups focusing on security and electronic authentication techniques to ensure the inclusion of physicians' perspectives, and that such standards are in compliance with state and federal regulations. (BOT Rep. 10, I-01)

D-478.998 HIPAA Requirements for E-Commerce in Health Care

Our AMA will: (1) intensify its on-going effort to inform practicing physicians about the consequences of implementation (including financial implications) of the Health Insurance Portability and Accountability Act (HIPAA) regulations for transmission of electronic information; and (2) study strategies on implementation of the HIPAA regulations, such as a limit on the frequency of modifications, which will lessen the financial impact on physicians, with a report back to the AMA House of Delegates when final regulations are promulgated. (Res. 802, A-00)

D-478.999 Guidelines for Patient-Physician Electronic Mail

The BOT revisit "Guidelines for Patient-Physician Electronic Mail" when the proposed HIPAA guidelines, encryption, and pertinent federal laws or regulations have been proposed or implemented. (BOT Rep. 2, A-00)

D-480.000 Technology

D-480.980 Direct-To-Consumer Advertising and Provision of Genetic Testing

Our AMA will study the issues of direct to consumer advertising of genetics tests and the provision of genetics testing to patients on the Internet or other vehicles not directly involving the patient's physician, taking into consideration appropriate mechanisms to regulate this practice. (Res. 522, A-07)

D-480.981 Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine

Our AMA will promote awareness among medical students and physicians of the wide use of complementary and alternative medicine, including its benefits, risks, and evidence of efficacy or lack thereof. (Sub. Res. 306, A-06)

D-480.982 RFID Labeling in Humans

Our AMA will study the medical and ethical implications of the use of radio frequency identification chips in humans. (Res. 6, A-06)

D-480.983 Medical Patents and Their Infringement on the Art of Medicine

Our AMA will reiterate its support for the Ganske Compromise and discourage the medical community from soliciting patents on medical methodology. (BOT Action in response to referred for decision Res. 223, A-03)

D-480.984 Physician Information on Third Party Payer Performance

Our AMA will continue to make information about health plan performance a high priority, within existing budget and legal constraints, and encourage Private Sector Advocacy to continue with the many relevant and important issues already underway in terms of monitoring and analyzing health plan behavior and performance. (BOT Action in response to referred for decision Res. 102, I-00)

D-480.985 Home Anti-Coagulation Monitoring

Our AMA will study the issue of home self-monitoring problems including, but not limited to, (1) accuracy of equipment and disposables; (2) willingness and ability of patients to perform both self-testing and quality control as recommended by equipment manufacturers; (3) correct communication of results to a monitoring physician; and (4) willingness of a physician in the absence of any funding stream for payment to assume the responsibility and potential professional liability for overseeing home self-monitoring. (Res. 825, I-05)

D-480.986 Manufacturer's Representatives in Health Care Settings: Their Duties Relative to Patient Care

Our AMA will study: (1) the responsibilities of physicians who allow manufacturer's representatives to observe and provide technical

support in patient treatment; and (2) both the physician's and the manufacturer's representative's duties to the patient and the physician, delineating the expected behavior and quality assurance mechanisms applicable to manufacturer's representatives in any health care setting. (Sub. Res. 726, A-05)

D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing

Our AMA:

(1) recommends that genetic testing be carried out under the personal supervision of a qualified health care professional;

(2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information;

(3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test;

(4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information;

(5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms. (Res. 502, A-04; Modified: BOT Rep. 7, A-08)

D-480.988 Intravenous Catheters

Our AMA will encourage the manufacturers of intravenous catheters to continue to produce traditional-type IV catheters. (Res. 508, A-04)

D-480.989 Multiplex Genetic Testing in Newborns

Our AMA will continue to monitor developments in newborn screening and revisit this issue should the use of DNA-based newborn screening tests be more widely adopted by states (CSA Rep. 3, A-03)

D-480.990 Health Plan Liability for Complementary and Alternative Therapy Requests

(1) Our AMA shall consider legislation requiring health plans to indemnify physicians for plan mandated referrals to Complementary and Alternative Therapy ("CAT") providers. (2) Our AMA shall recommend that physicians include indemnification clauses for CAT referrals in all health plan contracts when such plans require referral for CAT. (3) The CLRPD shall change all references in the AMA policy database from "CAM" to "CAT" and that an appropriate cross-reference be developed in the database. (BOT Rep. 36, A-02)

D-480.991 Access to Medical Care

Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure. (Res. 130, A-02; Reaffirmation A-04)

D-480.992 Genetically Modified Crops and Foods

Our AMA will monitor the forthcoming final rule for plant pesticides from the Environmental Protection Agency and respond as appropriate. (CSA Rep. 10, I-00)

D-480.993 Reprocessing of Single-Use Medical Devices

Our AMA will urge: (1) the FDA to continue to revise the guidance as new data on the safety and efficacy of reprocessed single-use devices emerge; and (2) Congress that the FDA should be given an ample period of time to determine the outcomes of its enforcement guidance on single-use device reprocessing before legislative regulation is considered. (CSA Rep. 3, I-00)

D-480.994 FDA Intrusion into the Practice of Medicine

Our AMA will communicate to the Food and Drug Administration the principle that the agency not exceed its authority in the regulation of medical devices. (Res. 519, A-00)

D-480.995 Genetic Manipulation of Food Products/Consumers' Right to Know

Our AMA will review and report back on labeling issues associated with genetically modified food products. (Res. 518, A-00)

D-480.996 Medicare Payment for Pulse Oximetry

Our AMAwill request CMS to reinstate coverage for pulse oximetry determinations performed in a physician's office when a clinical indication exists. (Res. 126, A-00)

D-480.997 Teleconsultations And Medicare Reimbursement

Our AMA will: (1) request the Office of Inspector General, Department of Health and Human Services, to issue an advisory bulletin on the legality of CMS's reimbursement methodology for teleconsultations in Health Professional Shortage Areas and request a suspension of the application of the rule until that opinion is rendered; and (2) pursue federal legislation authorizing equitable payment for clinical services delivered via telecommunications technology. (BOT Rep. 5, I-99; Reaffirmation A-07)

D-480.998 Minimal Standards for Medical Product Reuse

(1) Our AMA will encourage the development of a set of guidelines for processing medical supplies and instruments which may be reused. (2) These guidelines address the issues of product performance, safety and sterility. (3) These guidelines be distributed to the health care industry . (Res. 502, A-99)

D-480.999 State Authority and Flexibility in Medical Licensure for Telemedicine

Our AMA will: (1) develop a policy regarding the practice of medicine as it relates to the prescribing of prescription-only pharmaceuticals or other therapies via the Internet; and (2) continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99)

D-485.000 Television

D-485.999 Unrealistic Expectations from Surgery on Television

Our AMA will oppose television programs that minimize the seriousness and risks of surgery and distort patient expectations. (Res. 609, I-04)

D-490.000 Tobacco

D-490.976 Tobacco Settlement Fund

Our AMA supports state and local medical societies in their efforts to formally request that local and state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum amount of the state's Tobacco Settlement Fund award annually to smoking cessation and health care related programs, and encourages society members and the public to demand this of their elected officials. (Res. 431, A-07)

D-490.977 Use of Tobacco Industry-Sponsored Cessation and Prevention Materials

Our AMA urges (1) that when physicians and health organizations provide information or materials on tobacco to patients and consumers, such information and materials should come from credible and trustworthy sources with expertise in tobacco control; and (2) physicians and health organizations to avoid providing to patients and consumers information or materials on tobacco that come from tobacco companies or other groups aligned with the tobacco industry. (Res. 411, A-07)

D-490.978 Tobacco Usage

Our AMA will: (1) advocate for the use of the tobacco settlement funds for informational public service campaigns related to smoking cessation, especially as related to young people; and (2) send a formal letter to the appropriate authority in each state and territory that was party to the tobacco settlement for an accounting of past and projected future expenditures related to smoking cessation, especially as related to young people. (Res. 408, A-06)

D-490.979 Banning Smoking in All Workplaces

Our AMA will (1) actively support national, state, and local legislation and actively pursue regulations banning smoking in all

workplaces; and (2) work to ensure that federal legislation banning smoking in all workplaces does not prohibit or weaken more strict state or local regulations. (Res. 903, I-05; Modified: Res. 401, A-06)

D-490.980 Support for Smoke-Free Public Places Legislation in Guam

Our AMA will support the passage of comprehensive smoke-free public places legislation in Guam. (Res. 405, A-05)

D-490.981 Congress Repeal 38 USC §1715, Thus Allowing Veterans Health Administration Health Facilities to Develop Smoke-Free Campuses

Our AMA will work to have Congress repeal 38 USC §1715, thus allowing Veterans Health Administration health facilities to develop smoke-free campuses. (Res. 713, I-04; Reaffirmation I-08)

D-490.982 Development of a National Smoking Cessation Quitline Network

Our AMA will advocate for a national smoking cessation quitline network, such as that proposed by the US Department of Health and Human Services, and work with other appropriate agencies and associations to increase physician awareness of these effective telephone counseling resources. (Sub. Res. 436, A-04)

D-490.983 Annual Tobacco Report 2003

Our AMA will continue to produce the Annual Tobacco Report. (BOT Rep. 7, I-03)

D-490.984 AMA Opposition to Securitization of Tobacco Settlement Payments

Our AMA will work in concert with state medical societies to protect the settlement funds, including issuing statements condemning the use of settlement funds as a way to remedy state budget crises. (BOT Rep. 3, I-03)

D-490.985 Tobacco Products Sold in Businesses that Dispense Medications

The Board of Trustees will report its actions on the Policy H-490.971 at the 2003 Interim Meeting. (Sub. Res. 425, A-03)

D-490.986 Support for US Surgeon General Richard H. Carmona, MD

Our AMA (1) thanks Surgeon General Richard H. Carmona for his recent testimony before Congress related to tobacco and for emphasizing that tobacco use is the leading preventable cause of death in the United States; (2) thanks Surgeon General Carmona for his support of the report of the Cessation Subcommittee of the Federal Interagency Committee on Smoking and Health, "Preventing 3 Million Premature Deaths/Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation"; and (3) will continue to work with Surgeon General Carmona and others to achieve strong FDA control of tobacco and nicotine and a tobacco-free society. (Sub. Res. 443, A-03)

D-490.987 Federal Interagency Committee on Smoking and Health

Our AMA will send a letter to the Secretary of Health and Human Services urging the Department to adopt the recommendations, in their entirety, of the Interagency Committee on Smoking and Health. (Res. 434, A-03)

D-490.988 Anti-Tobacco Poster Contest

Our AMA will encourage state and specialty medical societies to establish or support statewide anti-tobacco poster contests designed to promote awareness among young people about the harmful health effects associated with tobacco use. (Res. 418, A-03)

D-490.989 Expert Witness Testimony by Physicians on Behalf of Tobacco Companies

Our AMA will develop a mechanism to investigate claims of false statements by physicians in tobacco related testimony and identify the means to involve concerned state and specialty medical societies in the investigation, and to inform appropriate state medical licensing boards of any actions taken. (Res. 5, I-01)

D-490.990 Tobacco Control Efforts

(1) Our AMA, when requested by Federation societies, analyze legislation suggested or supported by any representative of the tobacco industry or entity with strong ties to the tobacco industry and compare this legislation with recommendations for effective tobacco control programs, such as those recommended by the Centers for Disease Control and Prevention, Public Health Service, or other

reputable public health organizations. (2) Such analysis be made available to all member societies of the Federation, along with recommendations for countering and opposing any portions which might impede effective tobacco control efforts. (Res. 409, A-01)

D-490.992 Assuring Adequate Funding for DOJ Tobacco Lawsuit

Our AMA will: (1) strongly support federal funding of the Justice Department lawsuit regarding tobacco industry racketeering at a level sufficient to create realistic prospects for a trial verdict or settlement clearly favoring public health and the American public; and (2) send a letter to the President, Attorney General, and appropriate members of Congress indicating this strong support. (Res. 407, A-01)

D-490.993 Recognizing Effective Use of State Tobacco Settlement Monies

Our AMA will: (1) formally recognize states that make substantial commitments to fund tobacco prevention and cessation programs using funds from their Master Settlement Agreement allotments, with special recognition provided to states meeting the recommended CDC funding levels for effective programming;
(2) publicize this recognition as widely as possible, such as through its own medical journals, newsletters, web site, and media briefings as well as by encouraging and facilitating publicity by its Federation partners; and be it further
(3) encourage and support the efforts of medical societies in those states currently not committing substantial funding for tobacco prevention programs to work with their public health partners, governors, and legislatures to increase spending for comprehensive tobacco prevention programs.
(4) encourage states to fund other creative health care initiatives, including treatment, education and research initiatives, with tobacco settlement dollars and assist state medical societies in promoting model legislation to accomplish this. (Res. 412, I-00)

D-490.994 Review of Options for Preserving State Tobacco Settlement

Our AMA will review and analyze options for preserving/securing the integrity of state tobacco settlement funds, and report back at the 2000 Interim Meeting of the AMA HOD. (Res. 406, A-00)

D-490.995 Allocation of Tobacco Settlement Funds

Our AMA will quickly initiate discussions with appropriate national and state organizations and individuals about launching a multi-state effort to use ballot initiatives and other appropriate mechanisms to direct allocation of tobacco settlement funding consistent, to the extent possible, with AMA Policy H-490.924. (Res. 421, I-99; Reaffirmation I-03)

D-490.996 Tobacco Control Summit Alliance

(1) Our AMA will seek financial resources and strategic partners to convene a "Tobacco Control Summit Alliance" in the year 2000 in order to establish an end-game strategy for tobacco control. (2) The report of this Alliance be transmitted to this House of Delegates and the media no later than June 2001. (Res. 420, I-99)

D-490.997 Urgent Action on States' Allocation of Tobacco Settlement Monies for Smoking Prevention, Cessation and Health Services

Our AMA will: (1) translate that commitment into immediate action through aggressive lobbying activities with the Administration and the Congress;
(2) encourage and work with state and specialty societies to vigorously lobby state legislatures to: (a) assure that a significant percentage (depending on the objectively determined needs of the state), of the tobacco settlement monies be set aside first for tobacco control, nicotine addiction prevention, cessation and disease treatment for tobacco control and related public health purposes and medical services; (b) assemble an appointed state level task force including experts in public health and program evaluation and consumer advocated, to determine the best utilization of those set aside monies through review of local needs and nationally established tobacco control guidelines and programs; and
(3) report back to the House of Delegates at I-99 on the progress of these actions as well as the status of actions from Substitute Resolution 431 (I-98), as previously requested. (Res. 428, A-99)

D-490.998 Tobacco Control and Settlement

Our AMA: (1) will undertake action to publicize, support and implement the elements of its policies that have not been adequately addressed by the Master Settlement Agreement and other agreements, including but not limited to:

(a) A complete ban on tobacco industry promotion and advertising;
(b) Regulation of tobacco sales, including a ban on vending machines and a mandate for behind the counter sales;
(c) Tax increases on tobacco products;

(d) Protection from environmental tobacco smoke;
(e) Regulation of nicotine as a drug by the Food and Drug Administration; and
(f) Look back provisions; and

(2) will work with Congress, the Administration and other groups to achieve public health goals and accomplish the issues addressed by our AMA policies through federal and state tobacco control legislation. (Sub. Res. 431, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

D-495.000 Tobacco: Labeling and Warnings

D-495.995 Active Support for "Screen Out"

Our AMA will inform all state and specialty societies about "Screen Out!" and encourage them to endorse this program, promote the AMA Alliance's "Screen Out!" Web site link, and encourage petition and letter-writing campaigns to ask the Motion Picture Association of America to rate all new movies with smoking "R." (Res. 402, A-08)

D-495.996 Opposition to Addition of Flavors to Cigarettes

Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of flavored tobacco products; and (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of flavored tobacco products. (Res. 435, A-08)

D-495.997 Support of Legislation Regarding Fire-Safe Cigarettes

Our AMA will seek federal legislation to require that all cigarettes sold in the United States be self-extinguishing. (Res. 903, I-06)

D-495.998 Department of Justice Lawsuit Against the Tobacco Industry

Our AMA will:

(1) continue to encourage the Department of Justice to seek other remedies in the suit against the tobacco industry including: (a) ending tobacco industry marketing and advertising to children including "point of sale" advertising, promotions and sponsorships and the range of additional marketing activities aimed at youth; (b) halting industry deception and false health claims including the use of misleading terms like "light" and "mild" cigarettes; (c) full disclosure of all tobacco industry documents; and (d) fully funding tobacco cessation that includes a national telephone quitline network, universal access to smoking cessation medication and counseling, an extensive media campaign, research and education of medical providers; and

(2) urge the Department of Justice to appeal federal district court decision limiting Racketeer Influenced Corrupt Organization (RICO) Act remedies in the lawsuit against the tobacco industry and not enter into settlement discussions in this case until all appeals are exhausted up to and including appeal to the US Supreme Court. (Res. 446, A-05)

D-495.999 Tobacco Warning Labels

Our AMA will enter into a dedicated coalition and devote resources toward advocating to Congress and the appropriate regulatory authorities for enhanced tobacco product warnings, such as those that follow:
(1) enlarged warnings and benefits of quitting tobacco to cover at least 50% of all major surfaces of any tobacco packaging;
(2) a rotating series of many bold messages, including phrases such as, "This product kills," "This product is addictive," "This product causes disease in nonsmokers," "This product causes impotence," and similar messages composed by the Department of Health and Human Services;
(3) the use of pictorial displays of tobacco-related diseases on tobacco packaging;
(4) referrals to tobacco cessation services on each package of tobacco; and
(5) analogous increases in the size and content of warnings used in all other tobacco advertising. (Res. 439, A-03)

D-500.000 Tobacco: Marketing and Promotion
(See also: Death; Preventive Medicine; Public Health; Tobacco; Tobacco: Labeling and Warnings; Tobacco: Prohibitions on Sale and Use)

D-500.997 Issuing a Postage Stamp to Commemorate the First Surgeon General's Report on Smoking and Health (1964)

Our AMA will (1) urge the Citizens' Stamp Advisory Committee to recommend that a postage stamp be issued in 2014 to commemorate (on the 50th anniversary of its release) the first Surgeon General's report on smoking and health and (2) will implement this action by sending a sign-on letter to the Citizens' Stamp Advisory Committee, with endorsements by national medical specialty

societies, state medical associations, and other appropriate health organizations. (Res. 420, A-07)

D-500.998 Smoking and Health to Remain a Top Priority for the CDC After Reorganization

Our AMA will:
(1) strengthen its support of tobacco control and encourage the Centers for Disease Control and Prevention to keep smoking and health as a top priority;
(2) urge the Director of the Centers for Disease Control and Prevention to ensure the high status and visibility of its tobacco cessation program; and
(3) urge the Director of the Centers for Disease Control and Prevention to strengthen the visibility of its Office on Smoking and Health by elevating its stature within the organizational structure of the agency so that the Office on Smoking and Health reports directly, or once removed, to the CDC director and that this be reflected on the organizational chart. (Sub. Res. 439, A-04)

D-500.999 AMA Opposition to Federal Financial Support of Tribal Smoke Shops

Our AMA will study and take appropriate action to address the practice of federal funding of tribal smoke shops and similar pro-tobacco ventures. (Res. 419, A-00)

D-505.000 Tobacco: Prohibitions on Sale and Use

D-505.998 International Trade Agreements

Our AMA will:
(1) monitor developments on US international trade agreements that involve the provision of medical services and the distribution and advertising of alcohol and tobacco;
(2) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that could affect physicians or the provision of medical services, and advocate applicable AMA policy;
(3) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that involve the distribution and advertising of alcohol and tobacco, and other pertinent public health issues, and advocate applicable AMA policy; and
(4) continue to strongly advocate for US ratification of the Framework Convention on Tobacco Control. (BOT Rep. 18, A-04; Reaffirmation A-07)

D-505.999 Launching a Multi-State Smokefree Workplaces Campaign in 2003

Our AMA encourage individual medical students, residents, and physicians -- as well as medical schools, hospitals, clinics, and physician practices -- to endorse, support, and lobby for local and state legislation where needed to prohibit smoking in public places and businesses. (Sub. Res. 923, I-02)

D-510.000 Veterans Medical Care

D-510.994 Health Care for Veterans and Their Families

Our AMA will : (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration. (BOT Rep. 6, A-08)

D-510.995 Health Care for Veterans and Their Families

Our AMA will: (1) work with state and specialty societies to review the report of the President's Commission on Care for America's Returning Wounded Warriors; and (2) prepare a report to the House of Delegates for the 2008 Annual Meeting with a critical assessment of the Commission's recommendations for ensuring timely access to necessary and appropriate medical and mental health care services for soldiers returning from Iraq and Afghanistan and their families. (BOT Action in response to referred for decision Res. 434, A-07)

D-510.996 Military Care in the Public and Private Sector

Our AMA will use its influence to expedite quality medical care, including mental health care, for all military personnel and their families by developing a national initiative and strategies to utilize civilian health care resources to complement the federal health care systems. (Res. 444, A-07)

D-510.997 Job Requirements for the Under Secretary for Health, Department of Veterans Affairs

Our AMA will strongly advocate, directly and in conjunction with Association of American Medical Colleges and other appropriate interested organizations, that Section 8 language in H.R. 4231 maintain the required search committee, the current four-year term of appointment, and the requirement that the Under Secretary of Health of the Department of Veterans Affairs be a medical doctor. (Res. 233, A-04)

D-510.998 The Department of Veterans Affairs Time and Policies for Part-Time Physicians

Our AMA will work with the Department of Veterans Affairs to encourage the VA to eliminate the fixed "tour of duty" and to allow part-time physicians to receive full credit for meeting all the missions of the VA, regardless of time of day when these missions are met. (Res. 702, I-03)

D-510.999 Veterans Health Administration Health Care System

Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA's payment for prescriptions written by physicians who have no formal affiliation with the VHA. (CMS Rep. 1, A-03)

D-515.000 Violence and Abuse

D-515.983 Risk of Violence in the Emergency Department

1. Our AMA will, in conjunction with hospital, emergency medicine, mental health and law enforcement organizations, document the actual incidence of violence in the Emergency Department, estimate trends in violence that may place healthcare providers at risk and develop a report on the risk of violence in the Emergency Department, and the report will be distributed to the appropriate stakeholders and government agencies in order to guide our AMA in its effort to assure optimal care for patients with behavioral conditions in overcrowded acute emergency settings and to catalyze the development of procedures to protect students, trainees, physicians, nurses, and other healthcare staff in the Emergency Department environment. (Res. 437, A-08)

D-515.984 Health Care Costs of Violence and Abuse Across the Lifespan

1. Our AMA urges Congress to commission the Institute of Medicine to study and issue a report on the impact and health care costs of violence and abuse across the lifespan.

2. Our AMA: (a) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse; and (b) will develop and implement a strategy to advocate for increased funding for such research.

3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment. (Res. 431, A-08)

D-515.985 Elder Mistreatment

Our AMA:
1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams and assume greater roles as medical advisors to APS services.
2. Promotes collaboration with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in establishing training in elder mistreatment for all medical students; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination.
3. Encourages the development of curricula at the residency level and collaboration with residency review committees, the Accreditation Council for Graduate Medical Education, specialty boards, and Maintenance of Certification programs on the recognition of elder mistreatment and appropriate referrals and treatment.

4. Encourages substantially more research in the area of elder mistreatment.
5. Encourages the US Department of Health and Human Services, Office of Human Research Protections, which provides oversight for institutional review boards, and the Association for the Accreditation of Human Research Protection Programs to collaborate on establishing guidelines and protocols to address the issue of vulnerable subjects and research subject surrogates, so that research in the area of elder mistreatment can proceed.
6. Encourages a national effort to reach consensus on elder mistreatment definitions and rigorous objective measurements so that interventions and outcomes of treatment can be evaluated.
7. Encourages adoption of legislation, such as the Elder Justice Act, that promotes clinical, research, and educational programs in the prevention, detection, treatment, and intervention of elder abuse, neglect, and exploitation. (CSAPH Rep. 7, A-08)

D-515.986 Update on Youth and School Violence

Our AMA will re-examine its role in implementing current AMA policies related to violence prevention, and include such issues in a strategic issue paper. (CSAPH Rep. 2, I-07)

D-515.987 Prevention of Violence in Schools

Our AMA will continue to study the timely issue of violence in our schools, including youth violence prevention and early identification and intervention, and issue a report at the 2007 Annual Meeting of the House of Delegates. (Res. 608, I-06)

D-515.988 Warning Labels on Video Games

Our AMA Council on Science and Public Health will: (1) work in conjunction with all appropriate specialty societies to prepare a report reviewing and summarizing the research data on the emotional and behavioral effects, including addiction potential, of video games; and (2) develop recommendations for physicians, parents and legislators based on the findings of this report. (Res. 421, A-06)

D-515.989 AMA Leadership in Dealing with Recent Mass Assaults

Our AMA will incorporate any relevant health care aspects of mass assault, including early detection or possible prevention modalities, into the agenda of the Commission on Youth Violence, by agreement of the Commission. (BOT Action in response to referred for decision Res. 409, I-99)

D-515.990 Domestic Violence Against Pregnant Women

Our AMA will increase public awareness about domestic violence against pregnant women. (Res. 429, A-05)

D-515.991 Labeling of Video Game Content

Our AMA will actively campaign for appropriate labeling of any video game that depicts acts of violence or aggressive acts so that these videos will be made available for purchase by adults only. (Res. 421, A-05)

D-515.992 Diagnosis and Management of Family Violence

Our AMA will:

(1) urge the Agency for Healthcare Research and Quality and the National Institutes of Health to fund research on the following:
(a) A national, multi-site interdisciplinary study of health care interventions that addresses the effectiveness of selected interventions for victims of family violence on improved lifetime health status, health care utilization, and a sense of safety and security.
(b) Potential adverse effects of assessment for family violence on documentation and reporting to law enforcement and child-protective services.
(c) Research on cost-effectiveness of health care responses to family violence.
(d) Research on the primary prevention of interpersonal violence through identification and intervention of abuse across the life span;

(2) inform physicians about educational tools to aid in assessment and management of family violence, such as the Consensus Guidelines developed by the Family Violence Prevention Fund and the AMA *Roadmaps for Clinical Practice: Intimate Partner Violence* monograph; and

(3) ask the AMA Advisory Council on Violence and Abuse to study strategies for the primary prevention of family violence and inform physicians of the findings. (CSA Rep. 7, A-05)

D-515.993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse

Our AMA, in conjunction with other members of the Federation and the National Advisory Council on Violence and Abuse will:

(1) identify and actively support state and federal legislative proposals designed to increase scientific knowledge, promote public and professional awareness, enhance recognition and ensure access to appropriate medical services for patients who have experienced violence and/or abuse;
(2) actively support legislation and congressional authorizations designed to increase the nation's health care infrastructure addressing violence and abuse including proposals like the Health CARES (Child Abuse Research, Education and Services) Network;
(3) actively support expanded funding for research on the primary prevention of violence and abuse, the cost of violence and abuse to the health care system, and the efficacy of interventions and methods utilized in the identification and treatment of victims of violence and abuse;
(4) actively study the best practices in diagnosis and management of family violence (including an analysis of studies not reviewed in the recent US Preventive Services Task Force Recommendations on Screening for Family Violence) and present a report that identifies future research and practice recommendations; and
(5)invite a Federation-wide task force to review and promote the best practices in the identification, management and prevention of family violence. (Res. 438, A-04)

D-515.994 Violence Activities

Our AMA will: (1) continue to work with interested parties to ensure the widespread dissemination and adoption of the goals outlined in the Declaration of Washington (see H-515.993), adopted by the World Medical Association last October; (2) endorse the efforts of the WHO to recognize the myriad health effects of violence on the world's citizens; and (3) work with the WHO and the WMA to disseminate the findings in the World Report on Violence and Health, working with the US Department of Health and Human Services or other governmental agencies as appropriate to make US physicians aware of the report. (BOT Rep. 9, A-03)

D-515.995 Time for Action on Youth Violence

Our AMA will advocate for a national task force of diverse organizations to address youth violence prevention (and not solely limited to school violence and community violence). (Res. 419, I-01)

D-515.996 Helping Physicians Respond to Family Violence

Our AMA will: (1) establish a committee of representatives from the National Advisory Council on Family Violence and the Council on Medical Education to include representatives from broad general membership of the AMA, including state society committees and various specialty organizations to: (a) identify the knowledge and skills needed by physicians to adequately identify, respond to and prevent violence and abuse; (b) identify recommended components for training and developing these skills within the medical education process; (c) explore the means to incorporate that training into current medical education; and (d) to establish a mechanism to respond to the anticipated proposals from the Institute of Medicine "Committee on the Training Needs of Health Care Professionals to Respond to Family Violence"; and (2) advocate for hospital and community support of violence survivor programs; (Res. 419, I-00)

D-515.997 School Violence

Our AMA will collaborate with the US Surgeon General on the development of a comprehensive report on youth violence prevention, which should include such issues as bullying, racial prejudice, discrimination based on sexual orientation or gender identity, and similar behaviors and attitudes. (CSA Rep. 11, I-99; Modified: BOT Rep. 11, A-07)

D-515.998 Resources for Victims of Domestic Abuse in the Adolescent Population

Our AMA will develop materials on domestic violence, partner abuse, date violence, and sexual violence (including but not limited to sexual assault, sexual harassment, stalking, and cyberstalking) that are suitable for use in junior high and high schools and work with the Alliance and state medical societies in an effort to ensure the distribution and placement of these materials in junior high and high schools around the country. (Sub. Res. 410, I-98; Modified: Res. 406, A-07)

D-520.000 War

D-520.998 Homeland and Global Public Health Security

Our American Medical Association will encourage our federal government to involve physicians and organized medicine not only in the preparedness planning to deal with the consequences of weapons of mass destruction but also in the strategic planning of preventing the use of medical knowledge for the development of such weapons.

Our AMA, cognizant of the homeland and global public health security interdependence, encourages the World Medical Association,

the World Health Organization and other appropriate medical associations to initiate similar actions through the national medical associations of member nations. (Res. 721, I-02)

D-520.999 De-Alerting Nuclear Weapons

Our AMA will send a letter to President Clinton and Congressional leaders asking that the President urgently develop policies with other countries to minimize the accidental deployment of nuclear weapons and other weapons of mass destruction. (Sub. Res. 414, A-99)

D-525.000 Women
(See also: Cancer; Civil and Human Rights; Pregnancy)

D-525.995 Investigating the Continued Gender Disparities in Physician Salaries

Our AMA, in collaboration with any appropriate affiliate bodies or professional organizations (e.g., the Women's Physician Congress), will study gender disparities in physician salaries and professional development (eg, promotions, tenure), the causes of the disparities; and report back at the 2008 Annual Meeting with recommendations on how best to advocate to eliminate the disparities identified. This study shall be stratified by age, specialty, practice type and academic vs. non-academic employment. (Res. 306, A-07)

D-525.996 Prevention of Harassment and Discrimination of Women in Medicine

(1) The AMA Women Physicians Congress will continue to monitor and disseminate information on harassment and discrimination of women in medicine.

(2) Our AMA will: (a) encourage the collection of grievance policies and procedures by the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education; (b) encourage institutions belonging to the Association of American Medical Colleges Council of Teaching Hospitals to continue to distribute, at resident orientation, a copy of their institution's sexual harassment policy; (c) forward this report to the American Hospital Association; and (d) support existing programs that address harassment, discrimination, and sexism.

(3) Our AMA will approve the Guidelines for Preventing and Addressing Harassment in the Medical Profession for posting on the AMA web site, and other distribution where appropriate. (CME Rep. 3, A-03; Modified: BOT Rep. 25, I-04)

D-525.997 Silicone Breast Implants

Our AMA shall monitor federal legislation and regulatory activities related to breast implants and advocate for a woman's right to choose silicone or saline breast implants for breast reconstruction or breast augmentation after being fully informed about the risks and benefits and for a registry for all patients with breast implants. (Res. 727, I-02)

D-525.998 Mammography Screening for Breast Cancer

In order to assure timely access to breast cancer screening for all women, our AMA shall advocate for legislation that ensures adequate funding for mammography services. (Res. 120, A-02)

D-525.999 Women's Health: Sex- and Gender-Based Differences in Health and Disease

Our AMA will: (1) commend the various federal agencies and medical association and women's health organizations that are providing valuable and credible physician/patient education on sex- and gender-based differences in health and disease; (2) encourage the Women Physicians Congress in its efforts to serve as a clearinghouse for organization resources and related information on sex- and gender-based differences in health and disease, including the use of various forums, such as the AMA Web site and Medem, to provide comprehensive and timely physician education resources on sex- and gender-based differences in health and disease; and (3) widely distribute this report to the Federation of Medicine, Association of American Medical Colleges, women's health organizations, and other relevant groups. (CSA Rep. 4, I-00)

D-600.000 Governance: AMA House of Delegates

D-600.961 Specialty Society Delegate Representation in the House of Delegates

1. Our AMA will immediately undertake efforts to expand awareness and use of the designation mechanism for specialty society representation, working wherever possible with relevant members of the Federation.

2. The system of apportioning delegates to specialty societies be enhanced by a systematic allocation of delegates to specialty societies

by extrapolating from the current process in which members designate a specialty society for representation. The recommended model will:
(a) establish annual targets for the overall proportion of AMA members from whom designations should have been received;
(b) adjust actual designations by increasing them proportionately to achieve the overall target level of designations;
(c) limit the number of delegates a society can acquire to the number that would be obtained if all the society's AMA members designated it for representation;
(d) be initiated with delegate allocations for 2008, following the expiration of the freeze, which ends December 31, 2007; and
(e) be implemented over five years because this will result in the least disruption to the House of Delegates and allow the process to unfold naturally.

3. The Board of Trustees will prepare annual reports to the House describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations, and recommending changes in strategies that might be required to implement existing policy on representation of specialty societies. In addition, the Board should, in these or other reports:
(a) develop a system for use among direct members to solicit their designations of specialty societies for representation, with an eye on how that system might be expanded or adapted for use among other members; and
(b) engage in discussions with specialty societies that will lead to enhanced data sharing so that delegate allocations for both state and specialty societies can be handled in parallel fashion.

4. Our AMA will include in the specialty designation system an option to permit those members who wish to opt out of representation by a specialty society to do so when any automatic allocation system is used to provide representation for specialty societies that are represented in the House of Delegates.

5. If any specialty society loses delegates as a result of the apportionment process, the specialty society shall have a one-year grace period commencing January 1, 2008. At the expiration of this one-year grace period, a phase-in period shall be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented.

6. AMA Bylaw 2.11111 grants state societies a one-year grace period following the freeze expiring December 31, 2007 (per Bylaw 2.121). At the end of the grace period, a phase-in period will be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented. (BOT Rep. 17, A-07)

D-600.963 Membership Rules

1. Our AMA will place a moratorium on the loss of current representation in the House of Delegates for any society that does not meet the current AMA guidelines for representation requirements as it pertains to the minimum number of AMA members.
2. This moratorium shall remain in place through December 31, 2007.
3. When this moratorium is lifted, any organization that does not meet the required number of AMA members will have a one-year grace period to meet the requirements for House of Delegates representation. (Res. 602, I-06)

D-600.964 Moratorium on Five-Year Review Percentage Guideline

Our AMA will place a moratorium on the loss of any organization's current representation in the House of Delegates for any society which does not meet the current AMA guidelines for representation requirements as it pertains to the percentage of AMA members, with this moratorium to remain in place through December 31, 2007; and when this moratorium is lifted, any organization which does not meet the required percentage of AMA members will have a one-year grace period to meet the requirements for House of Delegates representation. (Res. 603, A-06)

D-600.965 Resident and Fellow Representation in the AMA House of Delegates

Our American Medical Association will establish a mechanism for additional delegate representation of residents and fellows in the House of Delegates as follows:

(1) The Resident and Fellow Section will be awarded one resident delegate and corresponding alternate delegate for every 2,000 resident members.
(2) A resident or fellow candidate for each of these seats will be required to receive written endorsement from their state or specialty society, and elected residents shall sit with their endorsing society.
(3) Endorsed candidates shall be elected by the RFS in a manner prescribed by their Internal Operating Procedures.
(4) The endorsing society is strongly encouraged to provide full financial support to its resident and fellow delegate(s); however, if the endorsing society is unable to fund the resident or fellow, it is ultimately the responsibility of the delegate to obtain funding.
(5) Resident and fellow proportional representation shall be reviewed at the end of the fifth year of implementation. (BOT Rep. 20, A-06)

D-600.966 Professional Interest Medical Association Representation in the House of Delegates

Profession Interest Medical Associations granted representation in our AMA House since June 2006 include:

The American Association of Physicians of Indian Origin and the Korean American Medical Association are granted representation in the AMA House of Delegates. (June 2006) (BOT Rep. 18, A-06)

D-600.967 Notice Requirement for Changes in Delegate Allocation to AMA House of Delegates

The AMA will:
1. Provide a total of three delegate allocation reports. A preliminary report should be produced at the end of May and it should be based on projected year-end membership levels within each state. It should clearly note that in the report that projected, rather than actual, membership counts are being used. An intermediary report should be produced at the end of October, using actual year-to-date membership counts. The final report should be produced at the end of January of the following year using year-end actual data.
2. Ensure that the distribution list for delegate allocation reports continue to include AMA state field representatives, AMA membership account executives, and state society presidents, the delegation chairs, and each member of the states' delegation in the House of Delegates.
3. Explore the possibility of developing a system to distribute the delegate allocation reports in electronic format, either by e-mail, web page or both. (BOT Action in response to referred for decision Res. 607, I-00)

D-600.968 Representation of Specialty Societies in the AMA House of Delegates

Federation organizations, delegates, alternate delegates, and other interested parties will be encouraged to review the delegate allocation system for specialty societies that has been proposed by the Advisory Committee on Specialty Society Representation and provide the AMA Board of Trustees with comments by March 1, 2005. (BOT Rep. 1, I-04)

D-600.970 Report on the Request to Consider Freezing the Size of the HOD

Our AMA will develop a mechanism to facilitate the method by which members select the specialty society that represents them and report back to the House of Delegates at the 2004 Annual Meeting. (BOT Rep. 5, I-03)

D-600.971 House Ad Hoc Committee on Governance

The Ad Hoc Committee (on Governance) be permitted to conclude its work with the current report. (A-03) (Rep. of the House Ad Hoc Committee on Governance, A-03)

D-600.973 Unified Voice

The House of Delegates affirms the importance of our AMA speaking with a unified voice on behalf of American medicine. The House of Delegates asks the Board of Trustees and Speakers to continue to search for ways to build the necessary consensus on policy issues to maximize our AMA's effectiveness in representing physicians and their patients. (Report of the Committee on Organization of Organizations, A-03)

D-600.974 Litigation Center Cases to Combat Automatic Downcoding and/or Recoding

Delegates and alternate delegates should attend the open meetings of the Litigation Center. (BOT Rep. 31, A-02)

D-600.975 AMA Assembly Meeting Space

Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. (Res. 612, A-02)

D-600.976 AMA National Leadership Conference

Our AMA, during the National Leadership Conference, shall provide assistance to members of the Federation in the form of briefings and scheduling of meetings on Capitol Hill. (Res. 610, A-02)

D-600.978 AMA Resolutions Honoring Deceased Nonphysicians

Our AMA will permit the introduction of resolutions honoring deceased individuals who have given significant amounts of time and energy in service to the AMA or Federation societies, whether or not such individuals are physicians (Res. 602, I-01)

D-600.979 HOD Select Committee: Governance Committee

(1) The Speaker appoint an ongoing Ad Hoc Committee consisting of the Vice Speaker, two representatives of the Council on Long Range Planning and Development, a representative of Reference Committee F, and a representative from the Select Committee; with the following responsibilities:

(a) address the items referred to it in this report,
(b) examine the responsibilities and relationships among the AMA Executive Vice President, General Counsel, and Board of Trustees,
(c) review and make recommendations to the House of Delegates based in part on previous reports addressing governance, and
(d) provide ongoing reports to the House of Delegates at Annual and Interim Meetings until such time as the House deems that it has accomplished its charge, beginning with the 2002 Annual Meeting. The reports shall address the implementation of new recommendations, old recommendations, and policies that have not been fully implemented with respect to governance.

(2) The Select Committee be dismissed with thanks for a timely and cogent report. (Rep. of the HOD Select Committee, I-01)

D-600.980 Criteria for Representation of Small Societies in the AMA House of Delegates

(1) At the AMA Annual Meeting in the year 2005, the AMA CLRPD, in consultation with the AMA Board, shall provide the House with a recommendation on the AMA membership standards that medical associations should meet to be represented in the AMA HOD. (2) Consistent with Substitute Resolution 5, which was adopted at the 1999 Annual Meeting, the moratorium on removal of small medical specialty societies from the HOD when their membership levels fall below the standard set in Policy H-545.984 (as revised above) be lifted as of the AMA Annual Meeting in the year 2001. (CLRPD Rep. 3, A-00)

D-600.984 Specialty Organizations Seated in our AMA House of Delegates

The specialty organizations granted representation in our AMA House since June 1999 include:

(1) American Academy of Cosmetic Surgery, American Association of Gynecologic Laparoscopists, American Society for Aesthetic Plastic Surgery, Inc. (June 1999)

(2) The Society of Radiologists in Ultrasound and The Vitreous Society (June 2000).

(3) The American Association of Hip and Knee Surgeons and the American Society of Bariatric Physicians (June 2001).

(4) The American Academy of Pharmaceutical Physicians (June 2002).

(5) The American Academy of Hospice and Palliative Medicine, the American Academy of Psychiatry and the Law, the American Association for Hand Surgery, and the International Spinal Injection Society (June 2003).

(6) The Society of Laparoendoscopic Surgeons and the Infectious Diseases Society of America (June 2004).

(7) The American Academy of Disability Evaluating Physicians. (June 2005)

The five-year review of specialty organizations since December 1998 is as follows:

(1) The American Academy of Allergy, Asthma & Immunology is granted one year to correct its membership deficiency, as outlined in Section 8.54 of the AMA Constitution and Bylaws (December 1998).

(2) The American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology, Head and Neck Surgery, American Academy of Pain Medicine, American Academy of Physical Medicine & Rehabilitation, American Academy of Pediatrics, American Association of Neurological Surgeons retain representation in the AMA House of Delegates (December 1998).

(3) The Association of University Radiologists is granted one year to correct its membership deficiency, as outlined in Section 8.54 of the AMA Constitution and Bylaws (June 1999).

(4) The American Association of Plastic Surgeons, American Association of Public Health Physicians, American Association of Thoracic Surgery, American College of Allergy, Asthma and Immunology, American College of Physician Executives, and American Society of Hematology retain representation in the AMA House of Delegates (June 1999).

(5) The American College of Emergency Physicians, American College of Physicians - American Society of Internal Medicine,

American College of Gastroenterology, and American Medical Group Association retain representation in the AMA House of Delegates (June 2000).

(6) The American Academy of Otolaryngic Allergy, American College of Cardiology, American College of Chest Physicians, American College of Nuclear Medicine, American College of Nuclear Physicians, American College of Obstetricians and Gynecologists, American College of Occupational and Environmental Medicine, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Abdominal Surgeons, National Association of Medical Examiners, and the Triological Society retain representation in the AMA House of Delegates (December 2000).

(7) The American Association of Clinical Endocrinologists is granted one year to correct its membership deficiency, as outlined in Section 8.54 of our AMA Constitution and Bylaws (June 2001).

(8) The American Academy of Child and Adolescent Psychiatry, American College of Medical Genetics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Medical Directors Association, American Orthopaedic Foot and Ankle Society, American Pediatric Surgical Association, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Clinical Pathologists, American Society of Colon and Rectal Surgeons, Renal Physicians Association, American Society of Neuroimaging, American Society of Neuroradiology, Society of Cardiovascular and Interventional Radiology, Society of Critical Care Medicine retain representation in our AMA House of Delegates (June 2001).

(9) The American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Association for Vascular Surgery, American Society for Gastrointestinal Endoscopy, American Society for Reproductive Medicine, American Society for Surgery of the Hand, American Society for Therapeutic Radiology and Oncology, American Society of Cytopathology, American Society of General Surgeons, American Society of Plastic Surgeons, American Thoracic Society, American Urological Association, Association of Military Surgeons of the United States, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, Inc., International College of Surgeons, North American Spine Society, Society for Investigative Dermatology, Inc., Society for Medical Consultants to the Armed Forces, Society of American Gastrointestinal Endoscopic Surgeons and the United States and Canadian Academy of Pathology retain representation in the AMA House of Delegates, and the American Association of Clinical Endocrinologists is removed from probation and retains representation in the AMA House of Delegates (June 2002).

(10) The American Association of Electrodiagnostic Medicine, American Society of Clinical Oncology, American Society for Dermatologic Surgery, American Society of Maxillofacial Surgeons, Radiological Society of North America and Society of Thoracic Surgeons retain representation in the AMA House of Delegates (December 2002).

(11) The Aerospace Medical Association, American Academy of Family Physicians, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Neurology, American Association of Clinical Urologists, American College of Rheumatology, American Clinical Neurophysiology Society, American College of Medical Quality, Society of Nuclear Medicine, and The Endocrine Society retain representation in the AMA House of Delegates (June 2003).

(12) The American Academy of Allergy, Asthma and Immunology, American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology - Head and Neck Surgery, American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons and the American Society of Ophthalmic Plastic and Reconstructive Surgery retain representation in the AMA House of Delegates (December 2003).

(13) The American Academy of Cosmetic Surgery, American Association for Thoracic Surgery, American Association of Gynecologic Laparoscopists, American Association of Plastic Surgeons, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American College of Physician Executives, American Society for Aesthetic Plastic Surgery, Inc., American Society of Addiction Medicine, American Society of Hematology, and Association of University Radiologists retain representation in the AMA House of Delegates (June 2004).

(14) The American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine and American Medical Group Association will retain representation in the AMA House of Delegates. (December 2004)

(15) The National Association of Medical Examiners will be placed on a one-year grace period. (December 2004)

(16) The American Academy of Otolaryngic Allergy, American College of Nuclear Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons and the American Society of Retina Specialists retain representation in the AMA House of Delegates.

(June 2005)

(17) The Society of Radiologists in Ultrasound will be placed on a one-year grace period for review at the AMA's 2006 Annual Meeting. (June 2005)

(18) The American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Abdominal Surgeons, the National Association of Medical Examiners, and the Triological Society retain representation in the AMA House of Delegates. (November 2005)

(19) The American Association of Clinical Endocrinologists, American Association of Hip and Knee Surgeons, American College of Radiation Oncology, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Academy of Child and Adolescent Psychiatry, American Institute of Ultrasound in Medicine, American Medical Directors Association, Society of Critical Care Medicine, and the Society of Interventional Radiology will retain representation in the AMA House of Delegates. (June 2006)

(20) The American College of Medical Genetics, American Pediatric Surgical Association, American Society of Bariatric Physicians, American Society of Colon and Rectal Surgeons, American Society of Neuroimaging, American Society of Neuroradiology, and the Renal Physicians Association will be placed on a one-year grace period for review at the AMA's 2007 Annual Meeting. (June 2006)

(21) The Society of Radiologists in Ultrasound has its representation in the House of Delegates terminated at the conclusion of the 2006 Annual Meeting. (June 2006)

(22) The American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Society for Gastrointestinal Endoscopy, American Society for Surgery of the Hand, American Society for Therapeutic Radiology and Oncology, American Society of Cytopathology, American Society of Plastic Surgeons, American Urological Association, Association of Military Surgeons of the United States, North American Spine Society, Society for Vascular Surgeons, and the Society of American Gastrointestinal Endoscopic Surgeons will retain representation in the AMA House of Delegates. (November 2006)

(23) The American Society for Reproductive Medicine, the American Society of General Surgeons, the American Thoracic Society, the College of American Pathologists, the Congress of Neurological Surgeons, the Contact Lens Association of Ophthalmologists, the International College of Surgeons, the Renal Physicians Association, the Society for Investigative Dermatology, the Society of Medical Consultants to the Armed Forces and United States and Canadian Academy of Pathology retain representation in the AMA House of Delegates. (June 2007)

(24) The Academy of Pharmaceutical Physicians and Investigators, the American Society of Bariatric Physicians, the American Society of Colon and Rectal Surgeons, the American Society of Neuroimaging, the American Society of Neuroradiology, the American Pediatric Surgical Association, and the American College of Medical Genetics retain representation in the AMA House of Delegates at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirement at that point, or be given one year to come into compliance. (June 2007)

(25) The American Association of Neuromuscular & Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery, American Society of Clinical Oncology, American Society of Maxillofacial Surgeons, Radiological Society of North America, and Society of Thoracic Surgeons will retain representation in the AMA House of Delegates. (November 2007)

(26) The Society of Nuclear Medicine will be placed on a one-year grace period for review at the AMA's 2008 Interim Meeting. (November 2007)

(27) The Academy of Pharmaceutical Physicians & Investigators, American Academy of Dermatology, American Academy of Facial Plastic & Reconstructive Surgery, American Academy of Family Physicians, American Academy of Neurology, American Academy of Psychiatry & the Law, American Association for Hand Surgery, American Association of Clinical Urologists, American Clinical Neurophysiology Society, American College of Medical Genetics, American College of Medical Quality, American Pediatric Surgical Association, American Society of Bariatric Physicians, American Society of Colon & Rectal Surgeons, American Society of Neuroimaging, American Society of Neuroradiology, American Society of Ophthalmic Plastic & Reconstructive Surgery, International Spine Intervention Society and The Endocrine Society retain representation in the AMA House of Delegates. (November 2008)

(28) The Aerospace Medical Association, American Academy of Hospice & Palliative Medicine and the American Society of Addiction Medicine will be placed on a grace period of one year to bring themselves into compliance. The staff of these specialty organizations will be expected to work with AMA membership to develop a plan to increase their AMA membership and meet the responsibilities of National Medical Specialty Organizations as provided in Section 8.20 of the Bylaws. At the 2009 AMA Interim

Meeting the Board will report back to the House with any appropriate actions as outlined in Section 8.53 of the Bylaws. (November 2008)

(29) That the American Academy of Allergy, Asthma and Immunology, the American Academy of Ophthalmology, the American Academy of Orthopaedic Surgeons, the American Academy of Otolaryngology – Head and Neck Surgery, the American Academy of Pain Medicine, the American Academy of Pediatrics, the American Academy of Physical Medicine and Rehabilitation, the American Association of Neurological Surgeons and the Society of Nuclear Medicine retain representation in the AMA House of Delegates. (November 2008)
(BOT Rep. 24, I-98; BOT Rep. 9, A-99; BOT Rep. 33, A-99; BOT Rep. 11 and 25, A-00; BOT Rep. 34, I-00; BOT Rep. 2 and 32, A-01; Consolidated: CLRPD Rep. 3, I-01; Appended: BOT Rep. 1 and 39, A-02; Appended: BOT Rep. 22, I-02; BOT Rep. 5, A-03; Appended: BOT Rep. 27, A-03; Appended: BOT Rep. 15, I-03; Appended: BOT Rep. 3, A-04; BOT Rep. 27, A-04; Appended: BOT Rep. 23, I-04; Appended: BOT Rep. 1, A-05; Appended: BOT Rep. 33, A-05; Appended: BOT Rep. 15, I-05; Appended: BOT Rep. 35, A-06; Appended: BOT Rep. 23, I-06; Appended: BOT Rep. 32, A-07; Appended: BOT Rep. 10, I-07; BOT Rep. 6, I-08; BOT Rep 9, I-08)

D-600.987 Criteria for AMA House of Delegates Retention for Small Specialty Societies

Our AMA will: (1) study and issue recommendations concerning the feasibility of changing the 50% membership rule for medical specialty societies that fall below the 1,000 member threshold by changing to a membership percentage that "floats" with the US national percentage of AMA membership or other potential methodologies; and (2) institute a moratorium beginning at the 1999 interim meeting on removal of small medical specialty societies from the House of Delegates where their membership falls below the 1,000/50% membership threshold, and for this moratorium to end at the second meeting occurring after the House has acted on this membership rule study. (Sub. Res. 5, A-99)

D-600.992 Improving the Functioning of the House of Delegates

(1) To streamline and shorten the meetings of the House of Delegates, (a) All awards will be presented at the Interim Meeting during the Opening Session. Award recipients should be strongly encouraged to keep their remarks to two minutes, and notified that written comments can be submitted and will be distributed to the House of Delegates. (b) Speeches will be limited to: (i) AMA President; (ii) AMA Executive Vice President (only if necessary to present key internal initiatives and activities, and to be accompanied by a full written report); (iii) The presentation by the AMA Foundation should be given annually; (iv) The AMA Alliance should continue to have the opportunity to make a presentation at both the Annual and Interim HOD meetings; (v) Other individuals will be given the opportunity to speak at the Speakers' discretion. (c) The Membership Outreach Program should continue to be recognized at House of Delegates as a valuable outreach tool. (d) Recognition of the Board and Council chairs for further reports should be done in a more expedited fashion, whereby the Speaker will ask only whether the Board or any Council has late reports, rather than recognizing the chairs one-by-one.

(2) The Speakers should ensure that all Board of Trustees and Council reports, except those to be published in peer-reviewed journals, and resolutions, should be placed on the AMA web site for review by all physicians. Items of business should be posted on the site as soon as they are available (resolutions as soon as they are received and legally reviewed, and Board and Council reports as soon as they are approved by the appropriate bodies).

(3) Council secretaries and Board of Trustees staff will carefully review resolutions, and note those on topics under active study by the Board or Council. Resolutions on such topics will be grouped together in each reference committee with such notation. (Special Advisory Committee to the Speaker of the House of Delegates, I-99; Modified: BOT Rep. 19, A-04; CC&B Rep. 3, I-08)

D-600.993 Specialty Society Delegate Ballot

Our AMA: (1) staff be directed to hold specialty society delegate ballots cast in 2000, to be counted in 2001; and (2) CLRPD develop a specialty society Delegate apportionment process that utilizes existing resources. (BOT Rep. 26, A-00)

D-600.999 Specialty Society Delegate Allocation

The House call on all delegates, alternate delegates, and Federation organizations to provide feedback on the six alternatives outlined in this report or suggest other alternatives to the Council on Long Range Planning and Development. (CLRPD Rep. 2, A-01)

D-605.000 Governance: AMA Board of Trustees and Officers

D-605.987 Public Member on AMA Board of Trustees

Our AMA will not add a second public member position to the Board of Trustees. (BOT Rep. 14, A-07)

D-605.989 BOT Audit Committee and Governance Recommendations

The Board of Trustees' Audit Committee will monitor the implementation status of the governance recommendations that are still in-progress and include their assessment, until they are fully implemented, in the Board's annual report to the HOD on its accomplishments (Rep. of the HOD Ad Hoc Committee on Governance, A-03)

D-605.990 Reports of the Committee of the House of Delegates on Compensation of the General Officers

GENERAL BUSINESS EXPENSES AND PERQUISITES
(Rep. of the HOD Comm. on Compensation of the General Officers, A-01)

Air Travel

Domestic:
President, President-Elect, Immediate Past President, and Board Chair: The Committee recommends establishment of the policy that the AMA pay for coach fare with reimbursement for upgrades.

All others: The Committee recommends the establishment of the policy that the AMA pay for coach fare.

In rare instances, the Committee recognizes that short notice assignments may require first class travel because of the lack of availability of coach seating, and recommends authorizing such for all General Officers when necessary.

Foreign:
The Committee recommends reimbursement for Business Class air fare for authorized foreign travel, except Mexico, Canada, and the Caribbean, while on AMA business.

Per Diem Costs

The Committee, following the recommendations of the Ad Hoc Committee of Structure, Governance, and Operations of the AMA and the intent of the HOD, emphasizes that the President, President-Elect, Immediate Past President, and Board Chair are compensated as full-time equivalents and should function as such. The Committee also recognizes, following the recommendations of the Ad Hoc Committee of Structure, Governance, and Operations of the AMA and the intent of the HOD, that the shift in assignments to the President, President-Elect, Immediate Past President, and Board Chair has been made to reduce compensation costs. Thus far, the collected data verify that the intended shift in assignments has taken place with a noticeable reduction in per diem costs.

Spouse Travel

The Committee noted that the Standing Rules limit reimbursement of spouse travel to coach fares, only for the Annual, Interim, April and October Board meetings. However, recognizing the need for cost containment, the Committee recommends that reimbursement for spousal travel be provided at coach fare, only for the Annual and Interim meetings.

Membership in the International Club of the Drake Hotel

The AMA currently offers memberships in the International Club of the Drake Hotel for the Board Chair, Vice Chair, and the three President positions. The Committee has received data that these memberships are cost effective and appropriate. The Committee recommends continuing these memberships.

Audit of Board Expenses

The Committee recognizes that the Board currently assigns twice annual reviews of five percent of General Officers expense reports to the Committee on Organization and Operation of the Board. However, the HOD Committee on Compensation of General Officers, as part of its charge, will also review Board expenses and perquisites and include appropriate findings as part of its report.

COMPENSATION OF AMA GENERAL OFFICERS

July 1, 2001 through June 30, 2002
(Rep. of the HOD Comm. on Compensation of the General Officers, A-01)

In consideration of the cost for General Officers to maintain their practices while on AMA business, the Committee recommends that the following compensation rates be effective for AMA General Officers for the period July 1, 2001 through June 30, 2002.

(1) Increase compensation of the Board Chair, President, President-Elect, and Immediate Past President from $225,000 to $230,000;

(2) Increase compensation for other General Officers from $1,120 to $1,150 per day for weekdays, and from $560 per day to $575 for weekends (Saturday and Sunday);

(3) Continue the $15,000 stipend for the Resident Trustee; and

(4) Continue the $6,000 stipend for the Student Trustee.

July 1, 2002 through June 30, 2003
(Rep. of the HOD Comm. on Compensation of the General Officers, I-01)

(1) No change should occur in the compensation of the AMA General Officers for the period July 1, 2002 through June 30, 2003; and

(2) The cash compensation, benefits, and perquisites of the Public Board Member should be comparable to those of all non-officer, physician Board members.

July 1, 2003 through June 30, 2004
(Rep. of the HOD Comm. on Compensation of the General Officers, I-02)

(1) The annual stipend for the three Presidents and Chair remain at $230,000 for the period July 1, 2003-June 30, 2004.

(2) The annual stipend for the resident and student Trustees remain at $15,000 and $6,000 respectively for the period July 1, 2003-June 30, 2004.

(3) Effective July 1, 2003, the per diem rate be a single rate of $1,150 for both weekdays and weekend days.

(4) Effective July 1, 2003, an annual discretionary fund of $3,000 each be established in the Board budget for the three Presidents and the Chair to pay for spouse travel expenses to accompany the Officer when the spouse is specifically invited to represent the AMA by participating in the program or by making a speech or presentation to the Alliance.

July 1, 2004 through June 30, 2005
(Rep. 1. of the HOD Comm. on Compensation of the General Officers, I-03)

(1) The annual stipend for the three Presidents and Chair will increase from $230,000 to $235,000 for the period July 1, 2004-June 30, 2005.

(2) The Chair-Elect compensation will be changed to an annual stipend at a rate of 75% of the rate the three Presidents and Chair and that the Chair-Elect receive $176,250 for the period July 1, 2004-June 30, 2005.

July 1, 2005 through June 30, 2006
(Rep. of the HOD Comm. on Compensation of the General Officers, A-05)

(1) The annual cash compensation for the Officers (President, President-Elect, Immediate Past President, and Chair) will remain at current 2004-2005 elected year level.

(2) The current honorarium and per diem levels for Non-Officer Trustees and the annual compensation for the Chair-Elect will remain at the current 2004-2005 elected year levels.

(3) The current compensation of the Medical Student and Resident will be increased to 50% of the honorarium provided to Non-Officer Trustees ($575) and 50% of the per diem for other assignment days ($575).

(4) The current annual allowance for each President for spousal travel will be increased to $6,000 for the period 2005-2006 using the same appropriateness criteria as stated in the current Standing Rules.

July 1, 2006 through June 30, 2007
(Rep. of the HOD Comm. on Compensation of the General Officers, I-05)

(1) All annual honorarium, honorarium rates, per diem rates and stipends for the AMA General Officers will remain at their current levels for the period July 1, 2006 to June 30, 2007.

(2) The current Standing Rules of the AMA Board of Trustees will be changed to permit first-class domestic airfare for only the President for travel over 1,000 miles or two hours flight duration.

(3) The allowance to the President for spousal travel will be increased to $10,000 annually using the same appropriateness criteria as stated in the current Standing Rules. The allowance to the Immediate Past President and President-Elect will remain at the current authorized annual level of $6,000.

July 1, 2007 through June 30, 2008
(Rep. of the HOD Comm. on Compensation of the General Officers, I-06)

(1) No changes from the current levels for annual honoraria, daily honoraria and per diems for the period July 1, 2007 to June 30, 2008.

(2) No changes to the current benefits, perquisites, services and in-kind payments for July 1, 2007 to June 30, 2008.

July 1, 2007 through June 30, 2008
(Rep. of the HOD Comm. on Compensation of the General Officers, A-07)

(1) There shall be an annual review of all compensation with appropriate inflation adjustments for both Honoraria and per diem rates. The compensation of the Chair-Elect will continue at 75% of the compensation of the Chair, President, President-Elect, and Immediate Past-President. The compensation level for the Medical Student and Resident/Fellow Trustees continue at 50% of other Officer compensation. Therefore:

- Given that Officer Honoraria was last increased in June, 2004, a 4% per year increase results in an Annual Officer Honorarium of $264,000 for the Chair, President, President-Elect and Past-President. This will result in an Annual Honorarium for the Chair-Elect equal to $198,000. They will continue to be paid monthly.

(2) Other Officer compensation will be split between a Governance Honorarium and Representation Per Diem (other than the Board Chairs and the Presidents). Therefore:

- The purpose of the Governance Honorarium is to compensate Officers for Scheduled Assignment Days (Board meetings and related travel days as approved by the Board). Governance Honorarium also includes Board, committee or task force conference calls, and all related preparation for any of the above.

- The purpose of the Representation Per Diem is to compensate Officers for additional travel related to Scheduled Assignment Days, Representation assignments, and special committee and/or council work as approved by the Board Chair. Additionally, the Board Chair may approve payment of Representation Per Diem for special circumstances, which may include special meetings of the Board.

- Other Officer (except for Medical Student and Resident/Fellow Trustees) annual Governance Honorarium increases to $50,000, paid monthly throughout the year. Medical Student and Resident/Fellow annual honorarium increases to $25,000 paid monthly, throughout the year. These amounts represent that portion of compensation considered to be Governance and are intended to compensate for the standard 38 days upon which the Honorarium has been historically based.

- Representation Per Diem continues at $1,150 per day for other Officers (excluding the Board Chairs and Presidents) and at $575 per day for Medical Student and Resident/Fellow Trustees.

(3) Officers (excluding the Board Chairs and the Presidents) who are assigned as the AMA representative to outside groups, as one of their specific Board assignments, will be paid a per diem rate for teleconference meetings, if that outside organization holds an official meeting via teleconference of at least two hours in length. Payment for these meetings would require approval of the Chair of the Board. The amount of the telephonic per diem will be 1/3 of the full per diem or $383 ($192 for the Medical Student and Resident/Fellow).

(4) Administration of the aforementioned compensation policy will be governed by the Standing Rules Relating to Travel and Expenses of General Officers.

(5) Final overall cost and effective date:

- The annual cost of implementing all of the above recommendations, assuming 4 telephonic representation meetings of at least 2 hours, equals $255,250 and is broken out as follows:

Increase to Chairs and Presidents Honorarium $137,750
Increase to Other Officer Honorarium $94,500
Estimated Increase for Telephonic Per Diem $23,000

- Due to the length of time since the last adjustments to compensation, these changes will be implemented immediately, effective July 1, 2007.

(6) Inflationary adjustments of Daily Meal cap in 2008:

- Beginning in January 2008, the Daily Meal cap will increase $5 per day, each year. Effective January, 1, 2008, the Daily Meal cap increases to $115.

July 1, 2008 through June 30, 2009
(Rep. of the HOD Comm. on Compensation of the General Officers, A-08)

1. An amount comparable on an after-tax-basis to the spousal allowance will be moved into the Honorarium of all Officers and a separate spousal travel allowance be eliminated effective January 1, 2008 so that the change reflects the full calendar year. The comparable amount is slightly above the existing allowance to acknowledge the increased tax burden the Officer will incur.

The following shows the impact of the change on the Honorarium.

President: $264,000 *(Current Honorarium)* + $15,000 *(Increase)* = $279,000 *(New Honorarium effective 1/1/08)*
Immediate Past President and President-Elect: $264,000 + $10,000 = $274,000
Chair: $264,000 + $ 5,500 = $269,500
Chair-Elect: $198,000 + $ 1,500 = $199,500
Officers (other than Medical Student and Resident/Fellow): $50,000 + $1,500 = $51,500
Medical Student and Resident/Fellow: $25,000 + $1,500 = $26,500

2. Organization Representation per diem, excluding conference calls, will be increased as follows:

- For Officers (excluding the Board Chairs and the Presidents and the Medical Student and the Resident/Fellow Trustees) will be increased to $1200 (a $50 increase), effective July 1, 2008.

- For the Medical Student and Resident/Fellow Trustees, continue the Organization Representation per diem at 50% of the other Officers or $600 (a $25 increase).

3. Organization Representation via conference calls 2 hours or greater will be increased effective July 1, 2008.

For Officers (excluding the Board Chairs and the Presidents) who are assigned as the AMA representative to outside groups, as one of their specific Board assignments, pay a per diem rate for teleconference meetings, if that outside organization holds an official meeting via teleconference of at least two hours in length. Payment for these meetings would require approval of the Chair of the Board. The amount of the telephonic per diem will be ½ of the full per diem or $600 ($300 for the Medical Student and Resident/Fellow Trustees).

4. Officer business travel expense reimbursement will be aligned to the AMA policy for executive employees to ensure consistency and ease the administrative burden related to the expanded IRS reporting rules effective January 1, 2008. (Rep. of the HOD Comm. on Compensation of the General Officers, A-01; Rep. of the HOD Comm. on Compensation of the General Officers, I-01; Rep. of the HOD Comm. on Compensation of the General Officers, I-02; Rep. 1. of the HOD Comm. on Compensation of the General Officers, I-03; Rep. of the HOD Comm. on Compensation of the General Officers, A-05; Rep. of the HOD Comm. on Compensation of the General Officers, I-05; Rep. of the HOD Comm. on Compensation of the General Officers, I-06; Rep. of the HOD Comm. on Compensation of the General Officers, A-07; Rep. of the HOD Comm. on Compensation of the General Officers, A-08)

D-605.991 Governance Report

(1) The Executive Vice President shall invite the Presidents to join in the weekly conference calls with the Chair and Chair-Elect.

(2) The Board of Trustees will provide to new Trustees an abbreviated version of the prior Board development presentations.

(3) The Board of Trustees shall evaluate the benefits of membership in a national organization of non-profit governing boards to determine if their products, programs, and services would augment the Board's development program and assist the Board in meeting the diversity and scope of its responsibilities.

(4) The Board of Trustees shall consider having the Chair-Elect participate in an educational program for newly elected chairs of non-profit organizations or institute a process to have each Chair-Elect tailor a development program to address his or her unique needs.

(5) The Board of Trustees shall incorporate into its Standing Rules that the President's message be selected from one of the AMA's

top strategic priorities, as defined by the strategic planning process, and that it be approved by the Board.

(6) The Chair shall assign "open" invitations to the Presidents, whenever possible, unless there is a Trustee with special expertise or who has a special relationship with the requesting organization.

(7) The Board of Trustees shall develop more explicit criteria to guide the Chair and staff in accepting invitations for meetings and appearances, making assignments, and evaluating the effectiveness of the Representation Program.

(8) The Board of Trustees and EVP shall consider expanding the Board Representation Program by using Council, Section and Special Group members, and staff for the Representation Program and, to the extent possible, incorporate information on their involvement in the Board's annual report to the HOD on the Representation Program.

(9) The Board of Trustees shall expand the definition of the Representation Program to include any Officer or Trustee interaction with an external organization, including the media, on behalf of the AMA.

(10) The EVP shall review the current systems and procedures to ensure that the Presidents, Chair and Chair-Elect are aware of press releases and other significant external communications.

(11) The Speakers shall initiate a special program to recognize delegations, individual Delegates and Alternate Delegates who have developed mechanisms for sharing information and soliciting input on important issues.

(12) The Board of Trustees shall continue using its existing Intra-Board Committees to provide oversight of AMA activities in lieu of Select Committee Recommendation 10.

(13) Future reports of the Ad Hoc Committee shall not include those governance recommendations that have been completed or rescinded. (Rep. Of the Ad Hoc Cmte. On Governance, A-02)

D-605.992 HOD Select Committee: AMA Member Attendance at Board Meetings

The Board of Trustees shall review existing policy for attendance of AMA members at Board meetings as stated in Board Standing Rules and alter them so that the process is less cumbersome. The Board of Trustees shall develop criteria detailing indications for the use of Executive, Closed, and Limited Sessions with the goal to utilize such procedures as infrequently as possible, and the Board of Trustees shall report back as to the changes at the 2002 Annual Meeting. The Board of Trustees will submit to the House of Delegates an informational report at the 2002 Annual Meeting detailing the criteria it has established as to when a member of the AMA may not be present during Board deliberations. (Rep. of the HOD Select Committee, I-01)

D-605.993 HOD Select Committee: Standing Rules

The Board of Trustees should amend its Standing Rules and that the Bylaws be amended to indicate that the Speaker of the AMA shall be an ex officio member of the Executive Committee of the Board without the right to vote. (Rep. of the HOD Select Committee, I-01)

D-605.994 HOD Select Committee: Communication

Activities to promote communication between the Board of Trustees and staff should be an ongoing priority. (Rep. of the HOD Select Committee, I-01)

D-610.000 Governance: Nominations, Elections, and Appointments

D-610.999 Guiding Principles for House Elections

(1) The Guiding Principles for House Elections, as described in G-610.021, will be included in the AMA Election Manual that is distributed before each Annual Meeting of the AMA House of Delegates.

(2) Our AMA House of Delegates urges the Speakers of the House to organize and schedule candidates forums at upcoming Annual Meetings in order to determine if candidates forums can enhance the House's election process. (CLRPD Rep. 4, I-01)

D-615.000 Governance: AMA Councils, Sections, and Committees

D-615.983 Changes to Activities of the Council on Legislation

Our AMA will examine how the Council on Legislation can be of greater benefit to the AMA and its lobbying efforts, with a report

back by the 2007 Annual Meeting. (Res. 608, A-06)

D-615.984 Promoting IMG Physicians into Leadership Positions

Our AMA will provide the House of Delegates with a status report in five years on the leadership development progress of International Medical Graduates. (Res. 616, A-06)

D-615.986 IMG Section Bylaws

The AMA Bylaws will be amended to provide that all IMG Section members who are AMA members be allowed to vote in the election of members of the IMG Section Governing Council and that, at the IMG Section Annual Meeting, only those IMG Section members who are AMA members and who attend that meeting be allowed to elect Governing Council members to specific offices (Chair, Vice Chair, Secretary, Delegate, Alternate Delegate, At Large Member, Resident Member) and that this election process be reviewed three years after its final approval by the House of Delegates. (BOT Rep. 37, A-05)

D-615.987 International Medical Graduates on Accreditation Council for Graduate Medical Education

Our AMA will (1) encourage the candidacy of well qualified International Medical Graduates for the Council on Medical Education; and (2) strongly consider well qualified IMGs for nomination to the Accreditation Council for Graduate Medical Education Board of Directors. (CME Rep. 5, A-05)

D-615.988 The AMA and the Relative Value Update Committee

Our AMA Board of Trustees will prepare a report for the 2005 Interim Meeting that explains in some detail the history and evolution of the Relative Value Update Committee (RUC), that describes the current composition and operation of the RUC, that explains the relationship of the RUC to our AMA, and that explains the interaction between the RUC and CMS. (Sub. Res. 616, A-05)

D-615.997 AMA-MSS Speaker and Vice Speaker Reform

Our AMA Bylaws be amended to include the Speaker and Vice Speaker of the AMA-MSS as ex-officio, non-voting members of the AMA-MSS Governing Council. (Res. 1, I-98)

D-620.000 Governance: Federation of Medicine

D-620.993 AMA Dispute Resolution Activities

Our American Medical Association will (1) provide members of the Federation background information on dispute resolution as well as information on where such services can be obtained; (2) identify processes for interspecialty dispute resolution and encourage disputing parties to use those processes to resolve disputes within the house of medicine; and (3) study the implementation of various options of alternate dispute resolution for interspecialty conflicts and report back to the House at the 2006 Interim Meeting. (BOT Rep. 1, I-05)

D-620.994 Increased Collaboration Between the AMA and Osteopathic Association

Our AMA will continue efforts to collaborate with the American Osteopathic Association. (Res. 611, A-04)

D-620.995 Unity Project

Our House of Delegates will extend to the 2002 Annual Meeting the date for the Board report on the Unity Project. (BOT Rep. 22, I-01)

D-620.996 Transmission of the Report of the Federation Advisory Committee Status Update

(1) The Federation Advisory Committee (FAC) continue to encourage, facilitate, and document collaborative efforts among all levels of organized medicine.

(2) The FAC continue to actively pursue Federation Coordination Team projects that are currently underway.

(3) The FAC continue to serve as a resource to the Federation Unity Project and its workgroups.

(4) The AMA's investment in the Virtual Federation (VFED) be concluded. (BOT Rep. 31, A-01)

D-620.997 Medical Society Strategic Alliances and Mergers: Options for Collaboration and Consolidation

(1) Our AMA should facilitate broad distribution of this report and should make the report available in response to inquiries from medical societies and associations. (2) As part of its ongoing work, the Federation Advisory Committee is encouraged to track consolidation and merger activities in the medical association sector and make information on this trend broadly available to Federation organizations. (CLRPD Rep. 5, A-00)

D-620.998 Definition of the Federation of Medicine

The Federation of Medicine includes the AMA, organizations with voting representation in the AMA House of Delegates and their component societies that voluntarily relate to each other in an implied set of working relationships and understandings. (Jt. Rep. of the CC&B and CLRPD, A-00)

D-620.999 Impact of Non-Physician Health Professional Membership In Medical Societies

Our AMA will: (1) survey the state, county and national medical societies to determine which societies have members other than physicians and medical students; (2) analyze these non-physician membership categories in those medical societies to determine what influence if any, such membership, including non-voting participation on boards and committees, may have on societies' policy making and election of officers; and (3) report back at the Annual 2000 House of Delegates Meeting on the potential impact these membership policies have on legislative and regulatory advocacy regarding inappropriate expansion of non-physician health professional scope of practice and other important health policy initiatives. (Res. 607, I-99)

D-625.000 Governance: Strategic Planning

D-625.984 Friends of American Medicine

Our American Medical Association will explore the development of a fee-based patient organization, Friends of American Medicine, and report back to the House of Delegates at the 2004 Annual Meeting. (Res. 607, A-03)

D-625.985 AMA Vision Statement

The AMA Vision Statement, as described in Recommendation 1 above (See G-625.010) , and the key strategies described in this report serve as a basis for the development of the AMA Plan for 2004, which will be distributed to the House of Delegates at its Interim 2003 Meeting. (BOT Rep. 1, A-03)

D-625.986 Focusing the AMA

The AMA Board of Trustees and AMA Management consider the priorities assigned to AMA products and services by the Committee on Organization of Organizations and other information developed by the COO to create a more focused and strategic AMA consistent with its core purpose and values. The BOT should report back at the 2003 Interim Meeting on the actions and plans to achieve the objective of creating a more focused AMA. (Report of the Committee on Organization of Organizations, A-03)

D-625.988 Implementation of AMA Policy

(1) Our AMA Board of Trustees and the Council on Long Range Planning and Development, working through the E-Medicine Advisory Committee, shall continue the process of redesigning and expanding the AMA's Web page on policy and advocacy in order to make it more visible on the AMA Web site and more useful in communicating with the public and physicians about AMA policy and policy implementation efforts, identifying advocacy opportunities that the AMA might pursue, and facilitating the participation of individual AMA members in the activities of the AMA.

(2) Our AMA Board of Trustees shall continue its efforts to develop additional ways to promote and implement AMA policy in the Federation of Medicine, the health sector, and society. The AMA Board also should continue its efforts to identify and implement mechanisms to enhance unity of voice and action within the Federation of Medicine. (Jt. Rep. of the BOT and CLRPD, A-02)

D-625.989 AMA Strategic Direction for 2003 and Beyond

The modified AMA Vision Statement, as described in Recommendation 1 above, and the key activities described in this report shall serve as a basis for the development of the AMA Plan for 2003, which will be distributed to the House of Delegates at its Interim 2002 Meeting. (BOT Rep. 2, A-02)

D-625.990 Commission on Unity: A Progress Report

Our AMA HOD calls on all Federation organizations to work with the Commission on Unity by providing the Commission with comments and suggestions on its design for a system of participating organizations. (Rep. of the Commission on Unity, A-00)

D-625.991 Report of the Commission on Unity Resolution

(1) Our AMA Board of Trustees shall assume leadership responsibility for working with other federation organizations and shall convene the leadership of federation organizations to determine if and how the design of the Commission Unity can be achieved and to provide a reality test of the design.

(2) To assist the Board, a Special Advisory Group shall be appointed by the Chair of the Board of Trustees. It shall include broad representation of the Federation as well as the Chair and at least one other member of the Commission on Unity. The Federation representatives shall be selected from nominees submitted by Federation organizations and the Chair of the Special Advisory Group shall be selected by the members of the Group.

(3) Our AMA Board of Trustees shall give the following areas high priority:
(a) Determining what organization will become the Core Organization;
(b) Developing a process for involving Participating Organizations in the development of the annual advocacy and communications plan;
(c) Developing a formalized process for consulting with Participating Organizations on key issues;
(d) Describing the structure and functions of a Committee on Organizational Conduct and Cooperation and a dispute resolution process;
(e) Describing how the Core Organization's business relationships with the Participating Organizations should be formalized and expanded; and
(f) Identifying the best membership model for the success of the Commission's design.

(4) Our AMA Board shall submit a progress report at the 2001 Annual Meeting of the AMA House of Delegates. At the 2001 Interim Meeting, the Board shall provide a report that includes the detailed proposal for a final design, how the design could be achieved, a risk/benefit analysis, and a set of recommendations for consideration by the House.

(5) Our Board shall determine the likely costs associated with completion of this work and a specific approach for obtaining financial support from participating Federation organizations. (Report of the Commission on Unity, I-00)

D-625.992 Unity Project

(1) The governing bodies of all organizations represented in the AMA House be requested to review and provide feedback on the Commission on Unity (COU) Report and BOT Report 28 (A-01), entitled "Analysis of Alternative Mebership Models" and take positions on the recommendations in the COU Report. (2) All organizations that have not contributed be encouraged to provide financial support to the Unity Project as requested in the letters sent March and May, 2001. (BOT Rep. 30, A-01)

D-625.993 Transmission of the Report of the Federation Coordination Team: status update

Our AMA distribute the Roles and Responsibilities study widely to the federation and encourage medical societies to use it as a tool for planning future activities. (BOT Rep. 34, A-99)

D-625.994 Special Advisory Committee to the Speaker of the House of Delegates: Referred Items

Our BOT and CLRPD will work to develop a prioritization mechanism for actions taken by the House of Delegates that fits within the AMA Strategic Plan. (BOT Rep. 15, A-00)

D-625.997 Excellence in Governance: Implementation of The "Final Report of the Ad Hoc Committee on Structure, Governance and Operations (I-98)

(1) The Ad Hoc Committee on Structure, Governance and Operations, the Councils, the Speaker's Advisory Committee, and other individuals and entities be commended for their contributions to improving AMA's governance practices.

(2) Our Board, the CLRPD, and the CC&B regularly review association bylaws and policies to ensure that the recent clarification of roles and responsibilities continues to serve our AMA as it evolves.

(3) The Strategic planning process become more focused and more of a driving force in everything the AMA does and that the House and other organizational units assist by prioritizing their efforts in concert with the strategic plan.

(4) Our Board, Councils, and other organizational entities expand efforts to engage internal and external stakeholders in an effective,

regular, and timely manner.

(5) Our Board, particularly through its Audit Committee, continue oversight of the design of a comprehensive risk management program and provide assurance that there is continuous assessment of environmental and internal risk factors by the association.

(6) The communications initiatives begun this year expand both internally and externally so that key stakeholders are informed, involved and armed with the most timely information about AMA efforts and accomplishments.

(7) Our Board completes its evaluation the Representation Program and report to the HOD at Interim Meeting in 2000 (I-00) on actions taken.

(8) Our Board, House, Councils, Sections, and other governance groups regularly audit their governance practices, conduct self-assessments, and seek broad input about needed improvements.

D-625.998 AMA Strategic Direction for 2002 and Beyond

Our current AMA Vision Statement, the key issues identified in this report, and the key dimensions described in this report serve as a basis for the development of the AMA Plan for 2002, will be distributed to the House of Delegates at its Interim 2001 Meeting. (BOT Rep. 1, A-01)

D-625.999 Excellence in Governance: Implementation of the "Final Report of the Ad Hoc Committee on Structure, Governance and Operations"

(1) Future reports on the status of the recommendations of the Ad Hoc Committee on Structure, Governance & Operations not include those items that have been completed or rescinded.

(2) The Speakers of the House of Delegates appoint a Select Committee of this House ratified by the House prior to the end of this meeting, comprised of at least six members of the House of Delegates, said committee to be charged with the responsibility of: (a) Investigating the matter of Anderson v. American Medical Association, et al, and reporting back to this House of Delegates as to the results of its investigation; (b) Making recommendations as to appropriate actions that this House should take, including, but not limited to, actions regarding the structure and governance of our AMA until such time as the matter of Anderson v. American Medical Association, et al is resolved; and (c) Evaluating the roles and responsibilities of the Board of Trustees and the Executive Vice-President and making recommendations to minimize similar future conflicts.

(3) The Select Committee retain legal counsel to advise and assist the Select Committee in carrying out its charge and that such legal counsel be independent from all other parties and counsel involved in Anderson v. American Medical Association, et al, and that sufficient funds be appropriated for this purpose. (BOT Rep. 27, A-01)

D-630.000 Governance: AMA Administration and Programs

D-630.971 Assessing the Role of the AMA and the Implementation of the Patient Safety and Quality Improvement Act of 2005

1. Our AMA will study and assess the wisdom and feasibility of creating and/or partnering to create a Patient Safety Organization (PSO) under the auspices of the AMA and/or the Physician Consortium for Performance Improvement.

2. Our AMA will continue its inquiry and corresponding due diligence to consider whether the AMA itself should be a Patient Safety Organization and, if so, in what relationship to members of the Federation or other entities.

3. Our AMA Board Task Force on Quality, Safety and E.H.R. will provide timely updates to the AMA Board and a final report with recommendations to the Board at the 2009 Annual Meeting. (BOT action in response to referred for decision Res. 611, A-08)

D-630.972 Progress Report on Res. 606-A-06 Improving Collection of AMA Race/Ethnicity Data

Our American Medical Association will:
1. Continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.
2. Implement a test reinstating race/ethnicity questions on the annual physician survey. If the results of the test show this to be an effective mechanism for collecting these data elements, reinstate the questions for the entire survey population.
3. Adopt the Centers for Disease Control and Prevention’s minimum recommended list of race/ethnicity categories providing for multiple designations of race and ethnicity.
4. Modify AMA systems that support the data collection and transfer of these data elements as necessary.
5. Revise AMA Policy H-460.924, Race and Ethnicity as Variables in Medical Research, to protect and ensure the appropriate use

and/or release of the data collected under these programs. Such language is to be submitted for consideration at the 2007 Annual Meeting. (BOT Rep. 24, I-06)

D-630.973 Improving Collection of AMA Race/Ethnicity Data

Our AMA will:
(1) Explore strategies to consistently collect race and ethnicity data on all physicians in its database.
(2) Work to standardize race and ethnicity classification codes across all AMA databases and to update incomplete records in its existing databases with race/ethnicity data.
(3) Ensure that any use of collected race/ethnicity data shall comply with applicable state and federal restrictions on such use.
(4) Conduct a needs assessment to identify, and if appropriate, adopt appropriate technologies and infrastructures to help improve the completeness, consistency, reliability and standardization of our AMA race and ethnicity data collection with a progress report back to the House of Delegates at the 2006 Interim Meeting. (Res. 606, A-06)

D-630.974 Health Care Recovery Fund

Our AMA will: (1) convey to the AMA Foundation its desire that medical students, resident physicians and fellows, and young physicians be given special consideration and priority, along with all other physicians, beyond rebuilding medical practices, based on their degree of need, in distributions from any special disaster recovery funds; and (2) work with interested state and national medical specialty societies to publicize the existence of any special AMA Foundation disaster recovery funds and to identify and encourage applications from deserving recipients, especially among those who are medical students, resident physicians and fellows, and young physicians, and that these names be shared with the AMA Foundation as it considers grants from such funds. (Res. 605, A-06)

D-630.975 E-mail Forwarding Account as a Benefit of Membership

Our AMA will conduct a pilot program to develop and launch a personalized AMA e-mail forwarding account as a benefit of membership. (BOT Rep. 28, A-06)

D-630.976 Medical Staff Educational Resources

Our AMA will (1) incorporate distance education utilizing the AMA web site, in addition to the seminar and lecture education formatted programs, for medical staffs through the AMA Organized Medical Staff Section; and (2) offer distance education to its membership at a cost that does not exceed the cost for the development of the education programs. (BOT Rep. 25, A-06)

D-630.977 Media Campaign to Help Physicians Preserve Self-Governing Medical Staffs

Our AMA will work with Organized Medical Staff Section leadership to develop and place a commentary or viewpoint article highlighting the critical need for organized medical staff involvement in all patient care decisions in the hospital setting. (BOT Action in response to referred for decision Res. 705, A-05)

D-630.978 Implementing Mental Health Parity

The AMA Insurance Agency will continue to search for any insurance program that will include parity. (BOT Action in response to referred for decision Res. 612, I-99)

D-630.979 AMA Use of Social Security Numbers

Our AMA will:
(1) change the Student Membership Application to eliminate the Social Security Number requirement, by implementing the appropriate system and process changes to enable this change, with the new application and processes to be put in place for the 2007 membership year;
(2) retain the complete SSN as collected through other processing methods including the receipt of the Association of American Medical Colleges file itself in order to maintain the quality and accuracy of the AMA Masterfile;
(3) expand the use of the Medical Education number wherever possible in replacement of the use of SSN as a primary matching element;
(4) continue to actively evaluate and implement additional measures to further secure the data elements contained within the AMA Masterfile; and
(5) prepare a report for the 2006 Interim Meeting on the implementation of the changes to the student membership application and issues related to the security of confidential information. (BOT Rep. 3, I-05)

D-630.980 Health Insurance for Medical Students

Our AMA will work with the AMA Insurance Agency to investigate the feasibility of developing and marketing a health insurance plan that will be tailored to medical students, affordable, continuous, hassle-free, and more comprehensive than a catastrophic (major medical) plan, and report back at the 2005 Interim Meeting. (Res. 617, A-05)

D-630.981 Restriction of Pharmaceutical Advertising on the AMA Web Site

Our AMA will amend its current Advertising Guidelines on web site pharmaceutical advertising to state that: "There will be no pharmaceutical advertisements on the AMA web site which are directed towards patients." (Res. 602, A-04)

D-630.982 Change JAMA's Editorial Policies

The Board of Trustees will: (1) discuss with the editor of JAMA and the Journal Oversight Committee options for how and where to place disclaimers in JAMA and the Archives journals, indicating that editorial content within the journal does not represent official AMA policy; and (2) present a report to the House of Delegates at the 2004 Interim Meeting regarding the outcome of discussions about the use of disclaimers in JAMA and the Archives journals. (BOT Rep. 32, A-04)

D-630.984 Enhancing Operational Efficiency

The AMA Board, using the information derived from the Committee on Organization of Organizations and other sources, shall continue its efforts to streamline the AMA in order to enhance operational efficiency. (Report of the Committee on Organization of Organizations, A-03)

D-630.985 Cost of Governance

The AMA Board will review the costs of AMA governance, using the information derived from the Committee on Organization of Organizations, and develop recommendations on how to decrease these costs without adversely affecting the ability of the Association to achieve its mission. The Board should provide a progress report on this project at the 2003 Interim Meeting. (Report of the Committee on Organization of Organizations, A-03)

D-630.986 Increasing AMA Presence in Washington, DC

Our AMA Board of Trustees shall conduct an operational analysis to determine which functional areas of the AMA could be located in the Washington, DC area while ensuring the most efficient and effective use of our resources. (Sub. Res. 602, A-02)

D-630.987 HOD Select Committee: Anderson v AMA

In the event of a settlement of litigation in this matter, the negotiators be urged to resist any confidentiality agreement which might materially impede adequately informing the House of Delegates in closed session, of experiences that might lead to possible organizational changes, and that the Office of General Counsel prepare and submit a final report to the House of Delegates after the conclusion of the litigation Anderson v. AMA. (Rep. of the HOD Select Committee, I-01)

D-630.988 HOD Select Committee: Outside Legal Counsel

The General Counsel shall coordinate the retention of all outside legal counsel on behalf of AMA, unless the legal matter directly concerns the employment or performance of the General Counsel. (Rep. of the HOD Select Committee, I-01)

D-630.989 Risk Minimization

Our AMA should explore ways in which to avoid or minimize the risk or appearance that an employee would take action in representing AMA motivated in any part by the possibility of future employment. (Rep. of the HOD Select Committee, I-01)

D-630.990 HOD Select Committee: General Counsel

The Office of General Counsel shall develop criteria for consulting with outside counsel. (Rep. of the HOD Select Committee, I-01)

D-630.991 Use of Physicians' Identity Data

(1) Our AMA will continue to exert its best efforts to ensure that all licensing of AMA physician and student data protect the privacy and confidentiality of member and non-member physicians and medical students.

(2) Our AMA (a) proactively inform physicians and students with identity data in the Masterfile of their rights to elect "No Contact," and (b) report back at the 2002 Annual Meeting about the educational actions undertaken, definitions of "No Contact" options, and

the implications of selecting such options.

(3) Our AMA will continue its current practice (in effect since July 2001) to cease releasing physician Social Security Numbers for any reason absent a national emergency. (Prior to July 2001, the AMA released physician Social Security Numbers only to credentialers for matching purposes to expedite the granting of hospital privileges and inclusion of physicians into managed care plans.)

(4) Our AMA will continue to monitor collection and licensing of AMA Masterfile physician and medical student identity data and implement enhancements of Best Business Practices to try to minimize improper or inaccurate identity of a particular physician or student which might cause the physician or student substantial risk, economic loss, risk of identity theft or fraud.

(5) Our AMA will disclose publicly on the AMA web site a general view of data elements collected in any AMA Masterfile along with the purpose, benefits, and types of firms that license the data. (BOT Rep. 12, I-01)

D-630.992 AMA Distribution of its Membership List

Our AMA better communicate: (1) the nature, rationale, and benefits of its list services to members; and (2) the options which members have to exclude their name from lists sold to outside organizations. (Sub. Res. 603, A-99)

D-630.997 Reduction of High Tuition Costs for AMA Leadership Meeting

Our AMA will study methods to increase the financial support available to members who wish to attend the leadership meeting but face a financial hardship in doing so and study ways to increase participation in the annual Leadership Meeting. (Res. 606, A-99)

D-630.998 National Leadership Development Conference

(1) Our Board of Trustees will monitor closely the costs of future sessions of the National Leadership Development Conference. (2) Our AMA will continue to aggressively seek outside sources of funding to reduce the cost of attendance at future conferences. (BOT Rep. 3, I-99)

D-630.999 Use of Medical Education Numbers In Continuing Medical Education

Our AMA will make the Medical Education number easily accessible for all physicians. (Res. 301, A-01)

D-635.000 Governance: Membership

D-635.982 Resident and Fellow Section Recruitment Funding Initiative

Our AMA will explore the enhancement of resident marketing and strategies as the new AMA evolves. (BOT Rep. 30, A-04)

D-635.983 Mentoring Medical Students, Residents and Young Physicians for Membership

Our AMA will:
(1) encourage the active participation of Federation members in existing AMA programs with a mentoring focus; (2) establish and maintain an AMA clearinghouse for AMA members-only of mentoring programs across the Federation for physicians and medical students; and (3) continue to explore future mentoring opportunities. (BOT Rep. 8, A-04)

D-635.984 Promotion of Individual AMA Membership

Our AMA will seek cooperative marketing partnerships with each membership organization seated in our AMA House of Delegates, and the Board of Trustees will report back to the House of Delegates at the 2004 Interim Meeting regarding these efforts. (Sub. Res. 605, I-03)

D-635.985 Extending AMA Membership Opportunities to Students Enrolled In Programs Longer than Four Years

Our AMA: (1) shall expand AMA Medical Student Section membership to:

(a) Include student membership options longer than four years;
(b) Create a simple renewal program for students who have already obtained a multi-year membership, yet will be students for greater than the length of their initial membership;
(c) Outline an appropriate fee structure for these options; and
(d) Determine the recruiting rebate to be refunded to the chapters for these options; and

(2) recommends that state and county medical societies implement membership options for their state's medical students who are enrolled in medical school for longer than four years. (Res. 601. A-02)

D-635.986 IMG Section Listed on Membership Dues Statement

Our AMA will explore cost effective alternative membership marketing activities to educate members and potential members of the importance of the International Medical Graduates Section, as well as the other special interest group(s). (BOT Rep. 3, I-01)

D-635.987 AMA Offer Part-Time Active Status

The Advisory Committee on Membership will investigate the feasibility of defining and offering a part-time membership category for physicians under the age 65. (Board of Trustees Report 2, I-01)

D-635.988 AMA Life Membership Status

The Advisory Committee on Membership will explore the development of benefits and symbols of appreciation for the growing population of senior physicians. (BOT Rep. 1, I-01)

D-635.989 Communications

(1) Our AMA and its subsidiaries will develop and implement a comprehensive ongoing strategic membership communication plan for members and prospective members to include at least the following elements:

(a) Prompt and specific communications for new members;
(b) Customized direct communication means to meet individual member preferences;
(c) Effective means of two-way communications;
(d) Programmatic reduction or elimination in mailings and other communications that do not serve to promote membership acquisition and retention; and
(e) Sufficient resources to implement and sustain this plan.

(2) The ad hoc Advisory Committee on Membership to the Board of Trustees will be charged with ongoing evaluation and oversight of this comprehensive strategic membership communication plan. (Task Force on Membership Rep. 2, A-00; Modified CLRPD Rep. 1, A-03)

D-635.992 Transitional Loan Program

Our AMA will investigate the feasibility of offering a Transitional Loan Program, tied to AMA membership, for new or current members. (Res. 616, I-99)

D-635.993 AMA Membership without Dues

The Board of Trustees submit a report with recommendations to the House of Delegates for the 2001 Annual Meeting. (BOT Rep. 24, I-00)

D-635.994 AMA Dues Reduction

(1) The Advisory Committee on Membership (ACM) continue to monitor and assess membership pilot programs involving our AMA and other Federation units and report back to the Board of Trustees. (2) The ACM continue to explore the benefits and risks of membership dues reduction options. (BOT Rep. 25, I-00)

D-635.995 Resident Membership

The Advisory Committee on Membership will investigate alternative membership dues options for the Resident and Fellow Section. (BOT Rep. 26, I-00)

D-635.996 Delays in AMA Student Membership Processing

(1) Our AMA perform an internal evaluation of the procedures involved in the processing of medical student and other membership applications and take steps to decrease delays and increase service to applicants. (2) Our AMA take immediate interim action to use all appropriate resources to reduce the delay of the processing of student and other physician membership applications. (3) Our AMA report back at the 2001 Interim Meeting detailing the progress that has been made. (Res. 617, A-01)

D-635.997 Enduring Entity on Membership

The BOT, with input from the ad hoc Advisory Committee and the CLRPD, will assess the performance of the ad hoc Advisory Committee in three years and report back to the HOD. (Jt. Rep. of the Task Force on Membership and the CLRPD, A-00)

D-635.998 AMA Membership Communication Vehicle

Our AMA will continue to: (1) develop and implement improved, cost-efficient ways of communicating to members, and that progress in this area be reported to and discussed with the House of Delegates Advisory Committee on Membership on a regular basis; and (2) support AM News and a disclaimer in prominent print be displayed that it does not reflect official AMA policy. (BOT Rep. 22, I-00)

D-635.999 Collection of E-Mail Addresses

(1) Our AMA continue to strive to collect e-mail addresses for all physicians.
(2) E-mail addresses be provided to the Federation only for joint membership solicitations and not for discussion forums or other non-membership communications.
(3) Our AMA work with state and specialty societies to encourage HealthCarePro Connect (HCPC) to collect e-mail addresses such that physicians actively sign-up (opt-in) to particular society lists.
(4) Our AMA continue to promote a Members-Only area of the AMA Web site that includes Discussion Forums but will not develop and maintain a national Internet Physician Discussion Forum. (BOT Rep. 33, A-01)

D-640.000 Governance: Advocacy and Political Action

D-640.993 AMPAC Board of Directors

1. Our AMA Board of Trustees voted to:

<u>AMPAC Image and Messaging Strategy:</u>

A. Develop communications to potential donors based on primary issue of Medicare reimbursement;
B. Tie issues to messages of inclusion and protection;
C. Tie legislative and regulatory information to AMPAC;
D. Conduct an AMPAC branding campaign in AMA publications using ads and articles;
E. Use a variety of electronic and print communications vehicles
F. Communicate with donors and non-donors often and year-round; and
G. Target specific physician populations based on other issues of importance.

<u>AMPAC Donor Levels and Benefits:</u>

A. Increase AMPAC minimum suggested dues levels in collecting agent states;
B. Create a variety of major donor levels with appropriate benefits; and
C. Include AMPAC dues on AMA direct membership solicitations.

<u>AMPAC Communications and Promotions:</u>

A. Use special events for communications, fundraising and rewards, especially among major donors, while applying marketing and promotional techniques;
B. Conduct qualitative and /or quantitative research annually;
C. Use email and AMPAC web site for education and solicitation activities and also for deployment of AMPAC newsletter and online giving;
D. Develop a continual direct mail campaign to donors and prospects;
E. Create a more comprehensive AMPAC brochure;
F. Develop a peer-to-peer solicitation program; and
G. Issue an annual report on AMPAC activities.

<u>AMPAC Leadership and Governance:</u>

A. Create an ad hoc committee of the Board, with representation from the AMPAC Board, to revise the criteria for selection and performance evaluation for AMPAC Board members to include specific fundraising responsibilities;
B. Set minimum giving expectations for AMPAC Board members and leadership of the AMA; and
C. Create a fundraising training program and new member orientation for AMPAC Board members.

2. Our AMA Board of Trustees voted that if the ad hoc committee recommendation includes significant new responsibilities and increased time commitment for service on the AMPAC Board, consideration of increasing the size of the AMPAC Board will occur.

3. Our AMA Board of Trustees voted to:

AMPAC Contribution/Disbursement Strategy:

A. Continue and expand in-state events program;
B. Continue and expand Washington, DC, events program and take advantage of Capitol Hill location of new AMA office;
C. Create a program for in-kind fundraisers; and
D. Continue to support and maintain existing political programs. (BOT Action in response to referred for decision Res. 604, I-06)

D-640.994 Updating the AMA Government Relations Internship Program

Our AMA, in collaboration with the MSS Governing Council, will evaluate modifying and expanding the existing AMA Government Relations Internship Program based in the AMA Washington, DC office, with report back at the 2003 Interim Meeting.

Our AMA will establish a yearlong medical student fellowship program, with appropriate stipend, based in the Washington, DC office. The program is to be modeled after the existing Government Relations Internship Program positions, with the primary goal of enhancing advocacy for AMA priorities and engaging the younger AMA members. (Res. 615, A-03; Appended: BOT Rep. 8, I-03)

D-640.995 Building AMA-MSS Membership through Promotion of AMPAC and State Medical PACs

Our AMA will: (1) urge all delegates to annually recruit for American Medical Political Action Committee and state political action committees membership among all medical student members that they are in contact with; (2) where state laws permit, encourage all medical students (regardless of AMA membership) to join state medical society PACs; and (3) recognize the state and the medical student region with the highest percentage membership in AMPAC and/or state PACs at each annual meeting. (Res. 616, A-03)

D-640.996 AMPAC Activities

AMPAC will continue to: (1) provide a report of activities and summary of expenditures at each meeting of the American Medical Association House of Delegates; and (2) study alternative means that will allow physicians to contribute to political campaigns in ways that can favorably influence federal elections. (Sub. Res. 608, I-99)

D-640.997 Advocacy Training

Our AMA, in collaboration with national medical specialty and state medical societies, will develop programs to enhance physician advocacy skills relating to non-physician legislative and regulatory scope of practice initiatives and quality of patient care concerns. (Res. 612, A-00)

D-640.998 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)

D-640.999 Annual Opportunity for Federation to Meet in Washington, DC

Our AMA encourages members interested in meeting in Washington, DC to participate in the biannual AMPAC 1999 AMA Grassroots Conference on those years when the meeting occurs in that city and on alternate years to participate in one or more of the numerous Washington, DC events sponsored by many other medical associations. (Sub. Res. 611, A-99)