

REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–25, were presented by Patrice A. Harris, MD, MA, Chair.

1. ANNUAL REPORT

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2016 and 2015 and the Independent Auditor's report have been included in a separate booklet, titled "2016 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

2. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policy D-600.984

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Society of Hematology, American Society of Transplant Surgeons and the International Society of Hair Restoration Surgery for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). A summary of each group's membership data is attached to this report Exhibit A. A summary of the guidelines is attached under Exhibit B.

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit C.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by the organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. All three organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the 2016 Interim Meeting indicated that: American Society of Hematology, American Society of Transplant Surgeons and the International Society of Hair Restoration Surgery meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

That the American Society of Hematology, American Society of Transplant Surgeons and the International Society of Hair Restoration Surgery be granted representation in the AMA House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Society of Hematology	1,017 of 7,046 (14%)
American Society of Transplant Surgeons	142 of 659 (22%)
International Society of Hair Restoration Surgery	106 of 209 (37%)

Exhibit B - Guidelines for Representation in and Admission to the House of Delegates

- 1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
- 2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.
- 3) The organization must meet one of the following criteria:
 - 1,000 or more AMA members;
 - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
- 4) The organization must be established and stable; therefore it must have been in existence for at least 5 years prior to submitting its application.
- 5) Physicians should comprise the majority of the voting membership of the organization.
- 6) The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges and are eligible to hold office.
- 7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.
- 8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
- 9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
- 10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C - Responsibilities of National Medical Specialty Organizations

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting
5. To provide information and data to the AMA when requested.

3. 2016 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2016.

American Medical Association Grants & Donations For the Year Ended December 31, 2016 Amounts in thousands		
Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through Northwestern University)	Midwest Small Practice Care Transformation Research Alliance	\$ 446
Centers for Medicare & Medicaid	Transforming Clinical Practices Initiative-Support and Alignment Networks	441
Centers for Medicare & Medicaid Services (subcontracted through Brandeis University)	Episode Grouper for Medicare Project	35
Centers for Medicare & Medicaid Services (subcontracted through Mathematica Policy Research, Inc.)	Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Professionals	306
Centers for Medicare & Medicaid Services (subcontracted through Mathematica Policy Research, Inc.)	Quality Measures for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees	127
Centers for Disease Control and Prevention (subcontracted through Cleveland Clinic)	eMeasure Development & NQF Support-Hemolysis Measure	1
Centers for Disease Control and Prevention (subcontracted through National Association of Chronic Disease Directors)	Diabetes Prevention Program	84
Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)	Providers Clinical Support System for Opioid Therapies	<u>37</u>
Government Funding		<u>1,477</u>
American Association for the Advancement of Science	International Congress On Peer Review and Biomedical Publication	10
American Association of Colleges of Osteopathic Medicine	Accelerating Change in Medical Education Initiative	13
American College of Emergency Physicians	Qualified Clinical Data Registry Quality Measures	48
American College of Rheumatology	eMeasure Development for Glucocorticoid-Induced Osteoporosis	1
American College of Surgeons	Quality Measures for Perioperative Care	5
American Heart Association, Inc.	NQF Submission and Support-Thrombolytic Therapy	4
American Osteopathic Association	Accelerating Change in Medical Education Initiative	13
College of American Pathologists	Electronic Measure Specification and Testing for Pathology	11
Massachusetts Medical Society	International Congress On Peer Review and Biomedical Publication	15
The Physicians Foundation Inc.	International Conference on Physicians Health	20
The Physicians Foundation Inc.	Joy in Medicine Research Summit	10
The Physicians Foundation Inc. (subcontracted through American Medical Association Foundation)	Joy in Medicine Research Summit	<u>13</u>
Nonprofit Contributors		<u>163</u>
Aries Systems Corporation	International Congress On Peer Review and Biomedical Publication	10
BioMed Central	International Congress On Peer Review and Biomedical Publication	10
Prometric Inc.	International Medical Graduates Section Symposium	5

American Medical Association
Grants & Donations
For the Year Ended December 31, 2016
Amounts in thousands

Funding Institution	Project	Amount Received
UnitedHealth Group Inc.	Commission to End Healthcare Disparities	10
Contributions less than \$5,000	International Medical Graduates Section Symposium	3
Contributions less than \$5,000	International Medical Graduates Section Reception	<u>6</u>
Other Contributors		<u>44</u>
Total Grants and Donations		<u>\$ 1,684</u>

4. AMA 2018 DUES

Reference committee hearing: see report of [Reference Committee F](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy G-635.130

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2018 Membership Year

The Board of Trustees recommends no change to the dues levels for 2018, that the following be adopted and that the remainder of this report be filed:

Regular Members	\$420
Physicians in Their Second Year of Practice	\$315
Physicians in Military Service	\$280
Physicians in Their First Year of Practice	\$210
Semi-Retired Physicians	\$210
Fully Retired Physicians	\$84
Physicians in Residency Training	\$45
Medical Students	\$20

5. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2016. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships, HOD Policy G-630.040. These "Guidelines for American Medical Association Corporate Relationships" were incorporated into the corporate review process, are reviewed regularly and were reaffirmed at the 2012 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2016 RESULTS

In 2016, 42 new activities were considered and approved through the corporate review process. Of the 42 projects recommended for approval, thirteen were conferences or events, five were education or grant programs, seventeen were collaborations and seven were member service provider programs (Appendix B).

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

Appendix A - Corporate Review Process Overview

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Business, Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Improving Health Outcomes, Ethics, Enterprise Communications and Marketing (ECM) and Membership.

The CRT evaluates each project with the following criteria:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Fit or conflict with AMA Corporate Guidelines;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or CPT licensing.)
- Member service provider programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions only if there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.

- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees. The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B - Summary of Corporate Review Recommendations for 2016

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
CONFERENCES/EVENTS			
25293	Health Affairs Quality Forum – AMA as a co-sponsor at a Health Affairs conference on quality.	Booz Allen Hamilton, Inc. Federation of American Hospitals (FAH) Health Affairs Johnson & Johnson Services, Inc.	2/12/2016
27780	World Medical Association (WMA) General Assembly Meeting (October 11-14, 2017) – AMA as host and corporate sponsors for the WMA General Assembly Meeting in Chicago.	Cardinal Health Cerner Corporation Cvent, Inc. Epoch.com Henry Schein, Inc. IBM HealthCare Kaiser Family Foundation Medtronic Mercedes Benz USA, LLC Panasonic Corporation of North America ReadyTalk	5/25/2016
27797	Sandy Hook Promise Gala – AMA as a sponsor for the Sandy Hook Promise Gala.	Sandy Hook Promise	5/25/2016
27974	TEDMED & AMA Opportunities – AMA participation in TEDMED 2016.	TEDMED	7/6/2016
27981	MACRA-The Stakeholder Perspective Alliance for Health Reform – AMA as a co-sponsor for a briefing by the Alliance for Health Reform on MACRA and for the Alliance for Health Reform’s 25 th anniversary event.	Alliance for Health Reform Blue Cross Blue Shield (BCBS)	8/29/2016
28041	Financial Wellness Event – AMA as a co-sponsor for a financial wellness event targeting young physicians.	Physician Financial Partners-Millennium Brokerage Group	7/14/2016
28216	Bellin Health Practice Transformation Learning Days – AMA as a co-sponsor for a conference with Bellin Health to introduce their nine-step practice transformation network.	Bellin Health Systems	8/24/2016
28224	Health 2.0 Annual Fall Conference – AMA as a participant in the Annual Health 2.0 Fall conference and sponsorship of a lunch and learn private AMA event.	Health 2.0 LLC	8/24/2016
28451	2017 National Quality Forum (NQF) Annual Conference – AMA as a co-sponsor at the National Quality Forum (NQF) annual conference “Accelerating the National Agenda for Quality Measurement and Value.”	Anthem, Inc. Henry Ford Health System Federation of American Hospitals (FAH) National Committee for Quality Assurance (NCQA) National Pharmaceutical Council Novartis AG	10/10/2016
28541	HIMSS – AMA collaboration with HIMSS for Annual Conference Exhibition 2017.	Healthcare Information and Management Systems Society (HIMSS)	10/25/2016

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
28706	Gun Violence Prevention Program Sponsorship – AMA collaboration with the American Bar Association (ABA) to co-host a program on using public health strategies to prevent gun violence.	American Bar Association (ABA)	11/23/2016
28763	The Patient, the Practitioner and the Computer – AMA as a co-sponsor with Brown University for a symposium on how the computer has affected the practitioner and the relationship between the patient and practitioner.	Alpert Medical School Department of Family Medicine, Alpert Medical School Josiah Macy Foundation Memorial Hospital Physicians Foundation Rhode Island Community Foundation University Emergency Room Foundation at Rhode Island Hospital University Medical Foundation and Department of Pediatrics, Alpert Medical School	11/23/2016
	Health Datapalooza 2016 – AMA as a co-sponsor for Health Datapalooza 2016.	ABILITY Network, Inc. AcademyHealth Castlight Health Janssen Global Services, LLC MidasPlus, Inc. Noridian Healthcare Solutions, LLC Patient-Centered Outcomes Research Institute (PCORI) Pfizer, Inc. RowdMap, Inc. Signet Accel, LLC SureScripts	2/29/2016
EDUCATION/GRANT ACTIVITIES			
25436	Health Systems Science Textbook – Elsevier as a publisher for a text book on Health Systems Science.	Elsevier BC	9/23/2016
25562	CPT eLearning Course – Co-branding of a CPT e-learning course with Elsevier.	Elsevier BC	4/7/2016
27762	Edge-U-Cate Sponsorship Agreement – AMA as a sponsor for the Edge-U-Cate teaching program for medical staff on managing credentialing and privileging processes.	Edge-U-Cate, LLC	5/16/2016
28548	Student Debt Navigator – Partnership between AMA and IGrad on an AMA Student Debt Navigator to help medical students and residents on financial literacy and loan repayment.	IGrad	10/31/2016
28924	Co-branding STEP Forward Module – With the Society of General Internal Medicine.	Society of General Internal Medicine (SGIM)	12/13/2016
COLLABORATIONS/AFFILIATIONS			
25224	Joint Marketing with Practice Transformation Networks – Co-branding with Practice Transformation Networks for recruiting physicians into their practice transformation programs.	Arizona Health-e Connection Baptist Health Systems, Inc. Children’s Hospital of Orange County (CHOC) Colorado Department of Health Care Policy & Financing Community Care of North Carolina, Inc. Community Health Center Association of Connecticut, Inc. Consortium for Southeastern Hypertension	1/26/2016

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
		Control (COSEHC) Health Partners Delmarva, LLC Health Quality Innovators (HQI) Iowa Healthcare Collaborative L.A. Care Healthplan Maine Quality Counts The Mayo Clinic National Council for Behavioral Health National Rural Accountable Care Consortium New Jersey Innovation Institute New Jersey Medical & Health Associates d/b/a CarePoint Health Medical Group New York eHealth Collaborative New York University School of Medicine Pacific Business Group on Health PeaceHealth Ketchikan Medical Center Rhode Island Quality Initiative The Trustees of Indiana University University of Massachusetts Medical School University of Washington Vanderbilt University Medical Center Vizient, Inc. VHS Valley Health Systems Washington Department of Health	
25376	MedStartr Physician Led Innovation Crowdsourcing Challenge – AMA name and logo association with Medstarttr and partners for the 2016 Physician Innovation Challenge for AMA members.	Medstartr, Inc. American Osteopathic Association (AOA) AVIA Cedars-Sinai Context Media, Inc. EdgeOne Medical, Inc. Eight Bit Studios, LLC Health2047, Inc. Healthbox, LLC Insight Product Development, LLC MATTER Mobile Makes Academy, LLC Sandbox Industries Techstars Central, LLC	4/1/2016
25472	AMA Partnership with IDEA Labs – AMA Collaboration on a two-year relationship with Idea Labs with the goal of tackling opportunities in healthcare delivery and clinical medicine.	IDEA Labs	3/23/2016
25558	Initiative on Team-Based Care – AMA collaboration on a module on using team-based care to improve hypertension management in primary care practices.	Group Health Research Institute (GHRI)	4/26/2016
25561	Heka Health Pilot – AMA collaboration on a self-measured blood pressure (SMBP) phone app pilot with Heka Health and Allscripts.	AllScripts Healthcare Solutions, Inc. Heka Health, Inc.	9/12/2016
25565	Xcertia – AMA as a joint founding member of Xcertia, a nonprofit whose goal is to develop principles and guidelines for the evaluation and/or certification of digital health.	American Heart Association DHX Media Ltd. Healthcare Information and Management Systems Society (HIMSS) SocialWellth Xcertia	11/9/2016

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
25579	DynaMed License and Marketing – Agreement for <i>JAMA Network</i> registered users and AMA members for a free trial and discounted price of DynaMed Plus.	EBSCO Industries, Inc.	4/8/2016
25582	AMA/LexisNexis Co-Branded Provider Data Management Product – AMA collaboration with LexisNexis to improve the accuracy of information contained in online provider directories.	LexisNexis	4/15/2016
25609	Target: BP Initiative – AMA collaboration with the American Heart Association to co-lead national efforts to improve blood pressure control.	American Heart Association	4/21/2016
27865	IHTSDO Collaboration – AMA and IHTSDO to advise and consult on respective coding and terminology products.	International Health Terminology Standards Development Organization (IHTSDO)	6/8/2016
27926	Prediabetes Registry Turn-On Pilot – Collaboration to test electronic communications via prediabetes registry. No AMA logo use.	Epic Systems Corporation	6/28/2016
28048	AMA/CDC/Quest Collaboration – Collaboration between AMA, CDC and Quest to prevent Type 2 Diabetes.	Centers for Disease, Control and Prevention (CDC) Quest Diagnostics	8/2/2016
28082	Intermountain Healthcare, Omada, AMA Press Release –Collaboration between AMA, Intermountain Healthcare and Omada Health announcement on a diabetes prevention program pilot.	Intermountain Healthcare Omada Health, Inc.	7/22/2016
28297	Continuing Medical Education (CME) Credit Conversion Agreement with Qatar – AMA logo use in announcement of agreement between the AMA and Qatar Council for Healthcare Practitioners.	Qatar Council for Healthcare Practitioners (QCHP)	9/16/2016
28703	MedStar/AMA Usability Comparison Research – Medstar and AMA research on an onsite usability comparison of Electronic Health Records (EHRs).	Cerner Corporation Epic Systems Corporation MedStar Health	11/16/2017
28923	National Academy of Medicine Action Collaborative – AMA as an inaugural sponsoring member of the National Academy of Medicine’s Collaborative on clinician well-being and resilience.	National Academy of Medicine	12/8/2016
28964	Physician Opportunities Portal –Name and logo association with the AMA on the Physician Opportunities Portal (POP).	LocumTenens Soliant Health MD at Home The TASA Group Concentra Operating Corporation Doctors Making House Calls (DMHC) VolunteerMatch All For Good EmCare	12/22/2016

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
MEMBER SERVICE PROVIDER PROGRAMS			
25091	AMA Affinity Real Estate Services – AMA Affinity program for real estate loans and realtor services.	Tower Mortgage Corporation d/b/a Physician Loans	1/7/2016
25481	AMA Insurance Agency (AMAI) Travel Protection Plan– AMA insurance travel protection plan for physicians and their families.	National Union Fire Insurance Company Travel Guard Group, Inc.	3/24/2016
27962	AMA Affinity Hotel and Travel Program – AMA Affinity program for discounted hotel services.	Corporate Hotel Network LLC	7/6/2016
28047	AMA Insurance Agency (AMAI) Retirement Planning Program – AMA Insurance financial planning service for AMA members to assist with retirement goals.	InsMark, Inc. Millennium Brokerage Group	8/11/2016
28060	AMA Insurance Agency (AMAI) Long Term Disability Program – AMA Insurance disability benefits program for group practice physicians and their staff.	American General Life Insurance	7/29/2016
28061	AMA Insurance Agency (AMAI) Digital and Mobile Pet Insurance Program – AMA Insurance digital and mobile sponsored pet insurance program provided by FIGO.	Figo Pet Insurance Markel American Insurance Company	8/4/2016
28892	AMA Affinity Student Loan Refinance Program – AMA Affinity program for student loan refinance with Darien Rowayton Bank.	Darien Rowayton Bank (DRB)	12/9/2016

6. REDEFINING AMA’S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which called on our American Medical Association (AMA) to “develop a policy statement clearly outlining this organization’s policies” on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. Board of Trustees (BOT) Report 6-I-13 accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

It is widely understood that the leadership of the 115th Congress has committed itself to “repealing and replacing” the Affordable Care Act, though others in Congress have suggested less radical changes to the statute. The AMA, at the direction of the HOD, has outlined a number of health system reform objectives which should be considered by policymakers in making changes to the ACA. Specifically:

- Ensure that individuals currently covered do not become uninsured and take steps toward achieving coverage and access for all Americans.
- Maintain key insurance market reforms, such as coverage for pre-existing conditions, guaranteed issue and parental coverage for young adults.
- Stabilize and strengthen the individual insurance market.
- Ensure that low and moderate income patients are able to secure affordable and adequate coverage.

- Ensure that Medicaid, CHIP, and other safety net programs are adequately funded.
- Reduce regulatory burdens that detract from patient care and increase costs.
- Provide greater cost transparency throughout the health care system.
- Incorporate common sense medical liability reforms.
- Continue the advancement of delivery reforms and new physician-led payment models to achieve good outcomes, high quality and lower spending trends.

On March, 9, 2017, pursuant to the requirements of Fiscal Year 2017 Budget Resolution (S. Con. Res. 3), the House of Representatives Committee on Ways and Means and Committee on Energy and Commerce reported budget reconciliation recommendations to the Committee on the Budget. The resulting American Health Care Act (H.R. 1628) was reported by the committee on March 20, 2017 and subsequently debated by the House of Representatives on March 24, 2017. Lacking the necessary votes to advance the legislation, House leadership withdrew the bill prior to a vote.

According to the Congressional Budget Office, the American Health Care Act, with amendments approved by the House Rules Committee, would have resulted in 14 million Americans losing health care coverage in 2018. By 2026, it was estimated that 52 million Americans would have lacked health insurance, 24 million more than under current law. On March 22, 2017, the AMA wrote to House Speaker Paul Ryan and Democratic Leader Nancy Pelosi to inform the Congress that the AMA was unable to support “legislation that would leave health insurance coverage further out of reach for millions of Americans.” As in previous communications, the AMA also stated that we stand ready to work with Congress on proposals that will increase the number of Americans with quality, affordable health insurance.

As the AMA continues to discuss potential health system reforms with policymakers, and consistent with these principles and with other AMA policies related to health system reform, we will continue to pursue the objectives laid out in Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform.”

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-PERFORMANCE

Since the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), much of the policy making activity related to pay-for-performance programs has been subsumed by implementation activities surrounding that statute. The AMA has worked closely with policy makers throughout this process and significant progress continues to be made on the implementation of MACRA programs, including efforts to move reporting requirements on various elements of the proposal into better alignment with AMA policies. Final MACRA rules released in November 2016 demonstrate considerable improvement from proposed requirements. Among the improvements:

- As proposed, physicians would have been required to successfully report in all 4 Merit-Based Incentive Payment System (MIPS) categories in 2017 to avoid a penalty in 2019. The final rule requires only reporting on one measure for a single payment to avoid penalty.
- As originally proposed, a positive payment adjustment would have required reporting for a full calendar year. The final rule created a transition period that makes physicians who report for 90 continuous days eligible for a positive payment adjustment.
- The requirement for reporting a cross-cutting measure was eliminated as the AMA had advocated.
- The Centers for Medicare & Medicaid Services eliminated the acute and chronic composite measures and increased the size of the groups required to participate in the all-cause hospital readmission measure from 10 to 15.
- Reporting thresholds for successful participation in MIPS were reduced significantly to 50 percent of all patients in 2017 and 60 percent in 2018.
- Cost performance category of the composite score under MIPS is reduced to zero percent for 2017.
- Threshold for achieving full credit for improvement activities was reduced by one-third.
- Improvement Activities accommodations were made for small, rural, Health Professional Shortage Areas, and non-patient facing physicians as well as for Alternative Payment Models (APMs).
- Financial risk requirements for advanced APMs were reduced, and a broader array of patient-centered medical home certifying organizations is being recognized.

As outlined in the health system reform objectives above, the AMA will work to “continue the advancement of delivery reforms and new physician-led payment models to achieve good outcomes, high quality and lower spending trends” as part of continued MACRA implementation and health system reform efforts.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Independent Payment Advisory Board was created as part of the Affordable Care Act to reduce the per capita rate of growth in Medicare spending. Recommendations from the IPAB to reduce spending in Medicare are required should the Chief Actuary of the Centers for Medicare & Medicaid Services determine that per-capita spending exceeds a specified target. Should that occur, the IPAB would be required to make recommendations to Congress to bring spending back into line with targets. In doing so, the IPAB is generally prohibited from recommending changes to cost sharing or premiums, rationing care, or changing benefits or eligibility. These limits leave few tools for controlling spending outside of changes to provider payments. The statute also prescribes a specific time table for Congressional action on these recommendations which leaves Congress the option of replacing IPAB-recommended policies with alternative savings, though Congress would still be required to produce total savings necessary to match the targets. While these provisions have not been triggered since the implementation of the ACA, it is widely expected that the next determination this spring will call for modest cuts through the IPAB process.

At this time, no members have been appointed to the IPAB nor are appointments expected. The statute contemplates this possibility by calling for the Secretary of U.S. Department of Health and Human Services (HHS) to make the recommendation directly to Congress in lieu of recommendations made by an appointed IPAB. However, it is not clear at this time what steps the new Secretary of HHS would take in response to the triggering of the IPAB requirement nor is the position of the new Administration on this issue clear.

Six separate pieces of legislation have been introduced in the 115th Congress to repeal or otherwise discontinue the functions of the IPAB. Three of these bills, by Sen. John Cornyn (R-TX), Sen. Ron Wyden (D-OR), and Rep. Phil Roe, MD (R-TN) and Rep. Raul Ruiz, MD (D-CA) are consistent with legislation that has been introduced in each of the previous Congresses since the enactment of the ACA. In both the 113th and 114th Congress, bipartisan IPAB repeal legislation was considered and passed in the House of Representatives but not considered in the Senate. In each case, the bill was paired with provisions offsetting the cost that were not bipartisan in nature, therefore diminishing the opportunity for successful enactment. Unfortunately, the longer Congress waits to repeal the IPAB, the more expensive it will become given the fact that the Congressional Budget Office predicts accelerating Medicare spending in future years, increasing the likelihood of required cuts that must then be offset as part of repeal legislation. This year’s proposals are expected to be much more expensive than previous efforts.

The second set of proposals, introduced by the same sponsors as the IPAB repeal legislation, fulfills the requirements of an IPAB discontinuation process that was enacted as part of the IPAB itself. Section 3403 of the ACA establishes fast track procedures for discontinuing the IPAB process through a joint resolution that meets specific requirements. While these resolutions enjoy certain procedural advantages, they are likely to face the same scoring challenges as the repeal bills.

Though IPAB repeal is not expected to qualify for procedural protections in the Senate under the reconciliation process, the AMA will continue to seek opportunities to advance the proposals discussed above.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS, AND THE MEDICARE PATIENT EMPOWERMENT ACT

The AMA continues to seek opportunities to expand the use of health savings accounts and remove ACA imposed limitations on the allowed use of Flexible Spending Accounts funds.

Our AMA is working with the Health Choices Coalition in support of the “Restoring Access to Medications Act” which has been reintroduced by Rep. Lynn Jenkins (R-KS), Rep. Ron Kind (D-WI), Sen. Pat Roberts (R-KS) and Sen. Heidi Heitkamp (D-ND). This legislation would repeal ACA imposed limitations on the use of Flexible Spending Account funds to purchase over-the-counter medications without a prescription.

Our AMA also continues to pursue opportunities to expand the availability of Health Savings Accounts (HSA) consistent with AMA objectives for continuing health system reform. HSAs have been important elements in a number of proposals put forth in the health system reform discussion to date.

The Medicare Patient Empowerment Act has not been reintroduced in the 115th Congress. AMA will continue to seek opportunities, however, to increase private contracting opportunities under the Medicare program without penalty to the patient or physician.

STEPS TO LOWER HEALTH CARE COSTS

Beyond AMA's extensive efforts to prevent chronic disease currently underway through the Improving Health Outcomes initiative, there are multiple opportunities in the policy arena to bring down the cost of care, among them are focusing on the rising cost of prescription drugs and the opportunity to lower the cost of providing care through regulatory reforms.

There has been a good deal of discussion about the impact of the cost of prescription drugs on the total cost of care and on the ability of patients to afford to follow treatment regimens that have been prescribed for them. Many view the recent elections as an opportunity to open a dialogue on addressing prescription drug prices. As concepts like transparency and value based purchasing take hold in other areas of health care, it is to be expected that they would extend to the pharmaceutical arena.

AMA policy encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers, and health insurance companies. An AMA petition calling on these entities to introduce greater transparency in the processes for determining prescription drug prices had garnered more than 136,000 signatures to date. Our AMA has also launched an interactive grassroots campaign microsite, TruthInRx.org, where patients can leave their stories and access tools to help make their voices heard on Capitol Hill and in state legislatures.

Incorporating value into the pricing of prescription drugs is another strategy that can help to control health care costs and is supported by AMA policy adopted in November 2016 (Policy H-110.986, "Incorporating Value into Pharmaceutical Pricing").

Achieving lower cost care is also dependent on reducing the cost to the physician to provide the care by eliminating administrative burdens that do not contribute to better care. Our AMA has already engaged both Congress and the new Administration on a variety of proposals to reduce regulatory burden in the areas of certification and documentation, Medicare Advantage, Part D prior authorization requirements, Appropriate Use Criteria, Meaningful Use and Electronic Health Records, Program Integrity, DEA requirements, and FDA regulation of laboratory developed tests and compounding, to name a few. We will pursue the elimination of unnecessary and burdensome requirements through both regulatory and legislative channels.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

Guidance released by the Department of Health and Human Services in 2014 included a positive interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying that the section does not require "that a group health plan or health insurance issuer contract with any provider willing to abide by the terms and conditions for participation." Nevertheless, the AMA will continue to seek legislative opportunities to repeal this provision.

CONCLUSION

The 115th Congress promises the best opportunity to make important refinements to the ACA since the law's implementation. Our AMA will continue to work to promote AMA supported refinements as part of current congressional activities surrounding health system reform, consistent with AMA objectives and other policies, and report back at the next meeting of the House of Delegates.

7. AMA PERFORMANCE, ACTIVITIES AND STATUS IN 2016

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy G-605.050, “AMA Policy Database,” calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities and status for the prior year.

INTRODUCTION

The AMA’s mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extends across all physicians, as well as policymakers, thought leaders and medical schools, the AMA is uniquely positioned to deliver results-focused initiatives that enable physicians to answer a national imperative to measurably improve the health of the nation.

Professional Satisfaction and Practice Sustainability

The Professional Satisfaction and Practice Sustainability unit (PS2) is advancing initiatives that enhance practice efficiency, increase professional satisfaction and improve the delivery of care. Particular areas of focus include:

Practice Transformation: The STEPS Forward™ practice transformation modules, now in version 1.4, offer over 40 education and implementation modules that allow physicians and their staff to thrive in the new health care environment. The AMA held a conference of thought leaders and investigators on practice transformation and burnout to accelerate needed research on physician and staff well-being. The AMA also hosted a summit with leading health system CEOs to discuss physician wellness. The AMA launched a physician burnout assessment tool developed by the AMA with large group practices and health systems. The International Conference on Physician Health, hosted with the Canadian and British Medical Associations in September, was sold out. In addition, the AMA will join the National Academy of Medicine’s new Action Collaborative on Clinician Well-being and Resilience. In sum, AMA’s practice transformation tools and events reached or were utilized by over 40,000 individuals in 2016.

The AMA’s Centers for Medicare & Medicaid (CMS) Transforming Clinical Practices Initiative grant was renewed for 2017. The grant expands and enhances the AMA’s outreach to practices of all sizes by supporting their transformation efforts including their participation in Qualified Clinical Data Registries (QCDRs).

The AMA published the article, “Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties,” in the *Annals of Internal Medicine* highlighting for every hour physicians provide direct clinical face time to patients, nearly 2 additional hours are spent on Electronic Health Records (EHR) and desk work within the clinic day. The article was listed in Altmetrics Top 100 Articles of 2016, which ranks articles based on online discussions and use.

Digital Health: The AMA continues to engage EHR vendors and provide leadership to numerous digital health initiatives to incorporate needed changes in product design, training, implementation, and interoperability. The AMA’s digital health strategy is designed and implemented to inform, develop, and promote best practices for digital solutions, promote research to aid practicing physicians to incorporate these technologies to advance practice efficiency and improve outcomes, and ensure that the physician voice is represented in the design and implementation of these technologies. As part of this effort, the AMA formally announced our founding participation in Xcertia—a collaborative representing diverse stakeholders whose aim is to develop guidance for the mHealth community that focuses on issues of importance to physicians and their patients. We also completed and launched new digital health research focused on a summary view of physicians’ current motivations and requirements related to digital health.

Physician Payment: With the release of the first version of the Medicare Access and CHIP Reauthorization Act (MACRA) Payment Model Evaluator and payment related resources, AMA is assisting physicians to successfully participate in Medicare’s Quality Payment Program (QPP) and make the larger move to value-based reimbursement.

The AMA Payment Model Evaluator provides physicians with a brief assessment and educational resources to help them decide how their practice will participate in the new programs established under MACRA. We also continue to participate in private payer and industry initiatives on alternative payment models and quality improvement and measurement to assure that the physician voice is well represented.

Improving Health Outcomes

The AMA, in collaboration with the Y-USA and local YMCAs (under a CMMI innovation award to the Y-USA) helped to increase physician referrals of patients with prediabetes to the National Diabetes Prevention Program (DPP).

These data contributed to the decision by the Secretary of HHS to expand coverage for the DPP to all Medicare beneficiaries, beginning January 2018. This step is the first time that a preventive service model from the CMS Innovation Center has become eligible for expansion into the Medicare program.

The AMA, with the CDC, ADA and the Ad Council launched a national prediabetes awareness campaign that has yielded nearly a million visitors to the campaign website: doihaveprediabetes.org, where a risk test is available.

The AMA and American Heart Association (AHA) launched a national effort to improve blood pressure control in our nation. More than 500 physician practices and health systems have joined the effort, known as Target:BP. The AHA and AMA are providing a platform for data sharing and evidence-based tools and resources to support physicians and care teams and the patients they serve.

Accelerating Change in Medical Education (ACE)

In 2016, AMA, through the ACE initiative expanded to 32 schools, now reaching 19,000 MD and DO medical students who will provide 33 million patient visits annually when they enter practice. We are reaching approximately 1/5 of all medical students in the US with this initiative.

The AMA published an AMA textbook on “Health Systems Science” in December, which has already sold more than 1500 copies. It represents the “third pillar” of medical education – joining basic and clinical sciences to provide core information on health care delivery, quality improvement and patient safety, leadership, social determinants of health, population health and other related topics. In addition the AMA ACE Consortium published 15 scholarly articles and made 83 presentations at national, regional and international conferences and other events in 2016.

We supported adoption of the Indiana University SOM/Regenstrief Institute’s teaching Electronic Medical Record tool, which was deployed at three medical schools in 2016 and will be expanded to 4 additional schools in 2017.

AMA ACE sponsored a student-led conference on Health Equity and Working with Communities in August that was attended by more than 200 students and faculty. The host institution was UC –Davis.

AMA ACE schools began working with the AMA IHO strategic focus area to develop medical school curriculum resources on chronic disease management and prevention of diabetes.

Advocacy on behalf of the Profession

MACRA: As Medicare’s new physician payment system—the Quality Payment Program—created by the Medicare Access and CHIP Reauthorization Act (MACRA) began to take shape, the AMA secured several major improvements for physicians. These changes made MACRA more flexible for physicians, providing the opportunity for practices to have greater success under the new program. All six of the AMA’s objectives were achieved in the final regulations, including the ability for physicians to pick their pace of participation in the new program during the 2017 transition year; simplified requirements for the Merit-based Incentive Payment System (MIPS); a shortened reporting period; an exemption from the QPP for low-volume physicians; relief for small and rural practices; a modified MIPS performance threshold; and expanded opportunities for advanced alternative payment models.

Opioids: With the nation’s opioid epidemic claiming more lives than ever, the AMA Task Force to Reduce Opioid Abuse and the nation’s medical societies are making strides along several fronts. Opioid prescribing decreased

nearly 11 percent from 2013-2015, naloxone access expanded in nearly every state, use of prescription drug monitoring programs increased 40 percent from 2014-2015, and more than 9000 physicians became certified to treat opioid use disorders in the past year.

Mergers: As the U.S. faced the prospect of mega-mergers between four of the nation's largest health insurers, the AMA urged preservation of competition and strongly opposed the mergers. Successful advocacy from the AMA resulted in the Department of Justice (DOJ) and numerous state attorneys general opposing both mergers, as well as California urging the DOJ to block both mergers and Missouri blocking the Aetna-Humana merger. Both mergers were successfully blocked.

Drug Pricing: To help bring much-needed transparency to skyrocketing prescription drug prices, the AMA launched an interactive website to help voices be heard by members of Congress and state legislators. Over 100,000 activists have taken action and signed our petition calling on Congress to act on drug pricing, Truthinrx.org.

Publishing

On the publishing front, *JAMA* continues to expand the intellectual richness of The JAMA Network® with the addition of *JAMA Cardiology* and *JAMA Oncology*, and the release of a new, cutting-edge website that includes a split screen presentation of original research articles. We further extended the electronic reach of all of the journals by making the new site responsive to all browsers and devices, making The JAMA Network App available in the iTunes App Store, and dramatically increasing the circulation level for the electronic table of contents of *JAMA* and the specialty journals.

Innovation

Through partnerships, policy research and new product initiatives, the AMA is working with health care professionals across various sectors to improve physician processes and practice environments, industry standards, patient care and outcomes. Some of our current initiatives include:

Sling Health: Sling Health is a student-run biotechnology incubator that is now in place to help inspire and support cutting-edge medical technology development from the next generation of young entrepreneurs studying at Washington University, Harvard University, Massachusetts Institute of Technology, University of Pennsylvania and University of Minnesota.

Physician Innovation Network: The AMA Physician Innovation Network is a digital matchmaking website where physicians and entrepreneurs can connect online and collaborate on new digital health care solutions.

Digital Diabetes Prevention: The AMA, Omada Health and Intermountain Healthcare are developing an innovative system approach to reduce the alarming number of adults who develop type 2 diabetes. This collaboration will produce a blue-print that can be used by large health care organizations across the country. The new approach allows physicians to identify and refer at-risk patients to online behavior change interventions as part of the clinical workflow.

Communicating with physicians

As a result of the AMA's Enterprise Digital Strategy, the organization led notable upgrades to its physician-facing digital ecosystem, including relaunch of the website and *AMA Wire*, through a collaborative effort involving hundreds of stakeholders. The new platforms were developed based on best practices for the current digital landscape and to publish content that is organized and written in a manner that is user friendly for the consumer. AMA also upgraded all newsletters to be mobile friendly.

AMA also prepared for the brand revitalization initiative that will launch in 2017, enabling the organization to highlight AMA products and resources in a comprehensive way for the first time in a decade. 2016 activities included research, focus groups, and development of positioning and creative.

In preparation for the brand revitalization initiative, the organization made notable improvements in its visual identity across digital touchpoints. To reinforce AMA product offerings and link them to the brand, numerous products were also renamed. These efforts will receive increased visibility as the initiative gets underway.

EVP Compensation

During 2016, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was \$1,003,413 in salary and \$895,035 in incentive compensation. Other taxable amounts per the contract are as follows: a \$172,579 payment of prior years' deferred compensation, \$14,478 imputed costs for life insurance, \$7,620 imputed costs for executive life insurance, \$2,500 paid for health club fees and \$2,790 paid for parking. An \$81,000 contribution to a deferred compensation account was made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the "AMA 2016 Annual Report."

8. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2016 THROUGH FEBRUARY 2017

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2016 through February 2017 and is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE IN THE UNITED STATES: CDC MORBIDITY AND MORTALITY WEEKLY REPORTS (MMWR)

According to the Centers for Disease Control and Prevention (CDC) tobacco use remains the leading preventable cause of disease and death in the United States with an estimated 480,000 premature deaths annually. The current smoking rate for American adults 18 and older is 15% and the rate for youth under 18 is 11%. From March 2016 through February 2017 the CDC released 15 MMWRs related to tobacco use. Among the topics were youth and adult smoking rates, trends in e-cigarette use, tobacco-related cancer disparities, and smoking cessation in Medicaid recipients.

2016: https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2016/index.htm

2017: https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2017/index.htm

http://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2016/index.htm

Smoking Rates and Trends Show Increases in E-Cigarette Usage

From March 2016-February 2017, 9 MMWR reports contained studies on tobacco use and smoking rates. These reports provide useful data that researchers, health departments, community organizations and others use to assess and develop ongoing evidence-based programs, policies and interventions to eliminate and/or prevent the economic and social costs of tobacco use.

According to the April 15, 2016 MMWR, which was an analysis of data from the 2011-2015 National Youth Tobacco Surveys (NYTS), there were substantial increases in e-cigarette and hookah use among high school and middle school students, whereas significant decreases were observed in the use of cigarettes, cigars, smokeless tobacco, pipe tobacco, and bidis, resulting in no decline in tobacco use overall for this population. The NYTS is an annual cross-sectional, school-based questionnaire administered to US middle school (grades 6–8) and high school (grades 9–12) students. It reports on current tobacco use and frequency of use. The definition of current use is ≥ 1 day during the preceding 30 days and the definition of frequent use is ≥ 20 days during the 30-day period.

In 2015, 25.3% of high school students reported current use of any tobacco product, including 13.0% who reported current use of ≥ 2 tobacco products. Among all high school students, e-cigarettes were the most commonly used tobacco product, with 16.0% of high schoolers reporting use, followed by 9.3% reporting cigarette use. Among

middle school students, current use of any tobacco product was 7.4% and 3.3% used ≥ 2 tobacco products. E-cigarettes were the most commonly used tobacco product by middle school students (5.3% of students reporting use), followed by cigarettes (2.3%).

Current use of any tobacco product did not change significantly from 2011–2015 (24.2% of students to 25.3%). Among all high school students, however, significant increases were observed for current use of e-cigarettes (1.5% to 16.0%) as well as among middle school students (0.6% to 5.3%).

The June 10, 2016 MMWR looked at e-cigarette use among working adults. It analyzed data from the National Health Interview Survey (NHIS) 2014 which was the first time this annual survey included questions about e-cigarettes. According to the MMWR, an estimated 5.5 million (3.8%) of 146 million U.S. working adults were current e-cigarette users. An estimated 16.2% of current cigarette smokers, 15.0% of other combustible tobacco users, and 9.7% of smokeless tobacco users currently used e-cigarettes. The highest e-cigarette use prevalence was among workers in accommodation and food services (6.9%) industry.

NHIS data are collected annually from a nationally representative sample of the noninstitutionalized U.S. civilian population through a personal household interview. The NHIS adult core questionnaire is administered to a randomly selected adult aged ≥ 18 years in each sampled household.

Disparities Still Exist in Cancer Death Rates Despite Declines

The November 11, 2016 MMWR looked at disparities in tobacco-related incidence and deaths. Tobacco use causes at least 12 different cancers and is responsible for 30% of all cancer deaths in the United States. A decline in cancer incidences and deaths has been observed since 2004 but these declines vary by gender, race and socioeconomic status. The tobacco-related cancer incidence rate was 1.7 times higher among males (250 per 100,000) than among females (148 per 100,000), as was the death rate (131 per 100,000 males vs. 76 per 100,000 females). Both incidence and death rates of tobacco-related cancer decreased faster during 2004–2013 among males (-1.5% and -1.8%) than among females (-1.2% and -1.4%).

Tobacco-related cancer incidence and death rates were highest, but decreased fastest, among blacks compared with other racial/ethnic groups. Tobacco-related cancer incidence and death rates were highest, and the incidence decreased slowest, in counties with lowest educational attainment or highest poverty. The rates increased with age, and one third of cancer cases and two fifths of deaths occurred among persons aged ≥ 75 years.

Although many factors might contribute to tobacco-related cancer disparities, they generally align with disparities in cigarette smoking prevalence by sex, geography, and socioeconomic status. The authors highlight the need to identify targeted evidence-based interventions to reduce tobacco use among high risk populations.

Medicaid Expansion Linked to Expanded Smoking Cessation Efforts

In 2015, 27.8% of adult Medicaid enrollees were current cigarette smokers, compared with 11.1% of adults with private health insurance, placing Medicaid enrollees at increased risk for smoking-related disease and death (November 11, 2016 MMWR). The December 9, 2016 MMWR looked at how state Medicaid expansion increased eligibility for smoking cessation services. The report also tracked coverage for nine evidence-based treatments: in-person or individual counseling and the seven FDA approved medications. By expanding Medicaid eligibility under the Affordable Care Act, 32 states have extended Medicaid cessation coverage to about 2.3 million adult smokers who were not previously eligible for Medicaid. All 32 of these states covered some cessation treatments for all Medicaid expansion enrollees. Nine states covered all nine cessation treatments considered in this study for all Medicaid expansion enrollees, and 19 states covered all seven FDA-approved cessation medications for all enrollees.

Low income status is associated with higher smoking rates and higher risk of tobacco-related diseases. Providing and promoting evidence-based cessation coverage has been found to be a cost-effective way to help smokers quit. Among the Medicaid population in Massachusetts, an evidence-based, heavily promoted Medicaid cessation benefit was associated with a reduction in smoking prevalence, from 38.3% to 28.3% over a 3-year period. For each dollar spent on the benefit over a 3-year period, an estimated \$3.12 in medical savings occurred from averted cardiovascular hospitalizations alone.

AMA TOBACCO CONTROL ACTIVITIES

Knock Tobacco Out of the Park

The AMA is a member of a national tobacco control partnership that includes public health and advocacy organizations, as well as AMA Federation members. Among the activities this partnership engaged in is support for eliminating the use of smokeless tobacco at baseball venues. In March 2016, the AMA was one of several organizations that signed on to a letter to the commissioner of Major League Baseball (MLB) and the executive director of the MLB Players Association calling on them to implement policies that prohibit the use of all tobacco products by players, managers, coaches, other personnel and fans at all MLB venues. In December 2016, (MLB) announced a new labor agreement that makes progress on removing tobacco from the game. The new agreement prohibits all new MLB players from using smokeless tobacco, like chew, dip and snuff. Currently 12 of the 30 MLB stadiums are governed by city or state laws (California) that prohibit tobacco use by players and fans.

AMA Highlights Surgeon General's Report

In December 2016, the U.S. Surgeon General issued the first federal review of the impact of e-cigarettes on young Americans, calling it a major public health concern. The AMA featured this report in *Wire* identifying key messages to assist physicians in answering questions from patients. The AMA also released a joint statement with the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Congress of Obstetricians and Gynecologists.

”While adolescent use of tobacco has declined since the 1970s, tobacco use continues to be a major health



Tobacco policies adopted by the major studios between 2007 and 2013 allowed smoking in 42% of their top-grossing PG-13 films and exposed moviegoers to 47 billion tobacco impressions. The MPAA must replace failed policies with an R-rating standard that truly protects children.

Over the past decade, all six MPAA-member studios have adopted policies on tobacco in their youth-rated movies. These policies have failed young audiences in at least three ways:

- From 2007 to 2010, the studios reduced the share of PG-13 films with smoking by less than 25%, in absolute terms. There has been no progress since 2010, despite three more studios adopting policies.
- The number of tobacco incidents in a typical major studio PG-13 film with smoking in 2016 is nearly double what it was in 2007.
- Over the past decade, the major studios have accounted for 84% of PG-13 tobacco impressions delivered to theater audiences.

The MPAA and the studios have known since 2003 that on-screen smoking is a uniquely powerful threat to children's health. The US Centers for Disease Control and Prevention concludes that exposure to smoking in the movies causes youth smoking. Youth-rated movies with smoking (primarily PG-13) will recruit three million young smokers in this generation and cause one million tobacco deaths.

MAJOR STUDIOS' POLICY LOOPHOLES EXPOSE AUDIENCES

Company	Policy effective	PG-13 films with smoking	PG-13 tobacco impressions
DISNEY	2008	29% (9 of 31)	9.1 billion
FOX	2012*	47% (16 of 34)	6.1 billion
PARAMOUNT	2013	39% (9 of 23)	4.7 billion
SONY	2012	54% (15 of 28)	4.0 billion
UNIVERSAL	2007	44% (36 of 82)	5.9 billion
WARNER BROS.	2007	39% (40 of 99)	17.4 billion
TOTAL		42% (125 of 297)	47.2 billion

Data: Top-grossing PG-13 films released from effective date of policy to 11/13/16. Independent published no tobacco policies 2007-2016. 35% (87 of 244) of their top-grossing PG-13 films included smoking, delivering 13.3 billion tobacco impressions. *Estimated 1/3/12.

The film industry has done little, so far, to change that dire projection of addiction and disability. What can? **An R-rating for smoking that covers every producer, director, distributor and movie would protect every child.**

One little letter **R will save a million lives.**



Visit smokefreemovies.ucsf.edu for more data on tobacco in top-grossing films, updated weekly by Thumb Up! Thumbs Down!, a project of Breathe California of Sacramento-Emigrant Trails.

threat to young people and adults, and e-cigarettes are threatening to addict a new generation to nicotine,” the statement said. “The developing brains of children and teens are particularly vulnerable to nicotine, which is why the growing popularity of e-cigarettes among adolescents is so alarming and dangerous to their long-term health.”

Smoking in the Movies Entices Youth

The AMA continued its support for limiting youth exposure to smoking shown in movies. The AMA was one of several organizations including the American Academy of Pediatrics, American Heart Association, American Lung Association and others featured in a full-page ad in the movie industry trade publications, *The Hollywood Reporter* and *Variety*, in December 2016 (see above). The AMA and others in the Smokefree Movies coalition have been calling on the industry to put an R rating on movies showing tobacco use. The 2012 and 2014 Surgeon General’s reports supported actions that would eliminate tobacco use depicted in movies including the R rating and provided data that showed a link between smoking in the movies and youth initiation. The Centers for Disease Control and Prevention concludes that exposure to smoking in the movies causes youth smoking. Youth-rated movies with smoking (primarily PG-13) could attract three million young smokers in this generation and cause a million tobacco deaths.

AMA House of Delegates Continues to Support Strong Tobacco Control Policies

The AMA House of Delegates adopted new or modified its existing tobacco control policies at its Annual Meeting held in June 2016 and its Interim Meeting held in November 2016. Among the 8 adopted/reaffirmed policies was one that focused on the Pro-Tobacco Actions of the U.S. Chamber of Commerce and urged conscientious companies that are members of the U.S. Chamber of Commerce to call for an end to all pro-tobacco efforts within the organization. The House also reaffirmed its support for FDA regulation over all tobacco products including e-cigarettes and its support for banning the sale of tobacco products in pharmacies and health care settings.

Youth Surveillance Survey Key to Reducing Youth Tobacco Use

The AMA demonstrated its ongoing support for the NYTS by submitting a letter signed by AMA CEO Dr. James Madara to Dr. Timothy McAfee, then director of the Office of Smoking and Health at the CDC. The AMA acknowledged the importance of the need to gather comprehensive data on the attitudes, knowledge and behaviors of middle and high school students related to tobacco use. While other similar surveys capture data on high school students, the NYTS remains the only source of such information on middle school students. The data collected can be used by the AMA and its Federation members to formulate policies on prevention and on clinical interventions.

9. PHYSICIAN AND MEDICAL STAFF MEMBER BILL OF RIGHTS (RESOLUTION 819-I-15)

Reference committee hearing: see report of [Reference Committee G](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 819-I-15
REMAINDER OF REPORT FILED
*See Policies H-225.942 and G-620.080***

At the 2015 Interim Meeting, the House of Delegates referred Resolution 819, “Physician and Medical Staff Member Bill of Rights.” Resolution 819 was introduced by the Florida Delegation and asked that our AMA:

1. Support and adopt the following medical staff member bill of rights in order to be able to carry out professional obligations and to clearly define the rights which we hold to be self-evident and inalienable:
 - a. The right to care for patients without compromise;
 - b. The right to freely advocate for patient safety;
 - c. The right to be compensated for providing care;
 - d. The right to be evaluated by unbiased peers who are actively practicing physicians in the community and specialty;

- e. The right to care for our own well-being;
 - f. The right to full due process when privileges are challenged;
 - g. The right to privacy;
 - h. The right of medical staffs to be self-governed and independently advised;
 - i. The right of freedom from personal loss or liability for adverse outcomes relating to medical practice based on compassion and good judgment within community standards; and
 - j. The right to fair market and transparent economic competition in our communities between hospitals with or without employee physicians and other allied health care professionals and independent physicians and groups in the delivery of health care services and compensation based on appropriate community need; and
2. Encourage state medical associations to promote the formation of medical staff advocacy committees throughout these states; and
 3. Provide support for state medical associations in their efforts to aid medical staff advocacy committee's role with medical staff issues and communications between physicians and hospitals and any other appropriate agency.

Testimony on Resolution 819 was mixed. Some members favored adoption while others suggested that the proposed bill of rights is not something that should be adopted without a thorough review of each component, especially given the large volume of existing AMA policy on these and related topics.

DISCUSSION

Medical staff rights and responsibilities

Resolution 819 asks the AMA to adopt a “medical staff bill of rights.” A comprehensive review of more than 160 AMA policies and directives on medical staff topics reveals that the medical staff-related rights espoused in the first resolve clause are already addressed by existing AMA policy, albeit often in a nuanced fashion. Recognizing that the complexity of this body of policy makes it difficult to summarize in a useful manner, your Board believes the AMA should establish a high-level abridgement of these existing policies in order to provide more practical guidance for medical staffs and their advocates. As implied by the resolution, any such enumeration of medical staff rights—whether attributed to individual members or the organization as a collective—ought to be framed in terms of the responsibilities that give rise to these rights.

Your Board therefore proposes the adoption and widespread distribution of a concise series of fundamental medical staff rights and responsibilities based on existing AMA policy. Additionally, to improve the usability of the rich body of underlying AMA policy, we suggest that the AMA undertake a review and consolidation as necessary of its policies on medical staff topics.

AMA and state medical associations

Resolution 819 also asks the AMA to “encourage state medical associations to promote the formation of medical staff advocacy committees” and “provide support for state medical associations” in these efforts. Existing AMA policy already directs the AMA to take such action. Specifically, the AMA “supports efforts to foster more effective liaison between state and local medical societies and organized medical staffs, and better coordination of their activities,” and will work “with county medical societies and state medical associations to provide the counsel and services necessary to strengthen local organized medical staffs” (AMA Policy G-620.080). In furtherance of these goals, the AMA, through its Organized Medical Staff Section (OMSS) and a variety of related resources, supports physicians affiliated with medical staffs in their efforts to cultivate high-functioning medical staffs and improve patient safety and quality of care in their health care organizations. Physicians interested in representing the interests and concerns of their medical staffs at the local, state, and national level are encouraged to visit ama-assn.org/go/omss to learn more about and become involved with OMSS.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 819-I-15 and that the remainder of the report be filed:

1. That our AMA adopt and distribute the following Medical Staff Rights and Responsibilities:
 - I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
 - a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
 - b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.
 - c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
 - d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
 - e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
 - f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.
(See Policies H-225.957; H-225.961; H-230.976; H-230.982; H-375.960; H-230.989; H-230.993; D-225.977)
 - II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:
 - a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules, and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
 - b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
 - c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
 - d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
 - e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
 - f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.
(See Policies H-225.957; H-230.957; H-230.965; H-230.975; H-235.963; H-235.980; H-235.990; D-235.994)
 - III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:
 - a. The responsibility to work collaboratively with other members and with the health care organization's administration to improve quality and safety.
 - b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
 - c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
 - d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.

- e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
 - f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
(See Policies H-225.943; H-225.944; H-225.947; H-225.949; H-225.950; H-225.957; H-225.986; H-225.997; H-300.973)
- IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:
- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
 - b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
 - c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.
 - d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
 - e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
 - f. The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities.
(See Policies H-225.950; H-225.952; H-225.997; H-230.968; H-265.998; H-375.960; H-375.962; H-230.987; D-375.996)
2. That our AMA reaffirm Policy G-620.080, "Federation Organizations and Organized Medical Staff."

**10. CREATION OF AN AMA FUND FOR PHYSICIAN CANDIDATES
(RESOLUTION 606-I-14)**

Reference committee hearing: see report of [Reference Committee F](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 606-I-14
REMAINDER OF REPORT FILED
See Policy G-640.015**

BACKGROUND

Resolution 606-I-14, "Creation of the AMA Super PAC," introduced by the Georgia Delegation, called for the creation of an American Medical Association (AMA) super political action committee (PAC) to make independent expenditures for or against candidates for federal office, and to provide significant ongoing funding for this activity. The resolution was referred to the Board of Trustees (Board) with instructions to report back at the 2015 Annual Meeting. Board of Trustees Report 18-A-15, "Creation of the AMA Super PAC," provided background information on the growth of federal super PACs, their funding sources, common characteristics of these organizations, and identified benefits and risks associated with the creation of a super PAC for the AMA. The report concluded that AMA corporate funds should not be used for this purpose and that the Board would continue to study the feasibility of creating a super PAC by exploring potential sources of outside funding while assuring that the ongoing activities and fundraising of the American Medical Association Political Action Committee (AMPAC) would not be negatively affected. The report was referred back to the Board for further study.

Board of Trustees Report 16-A-16, "Creation of the AMA Super PAC," detailed additional research that was undertaken to assess the advantages and disadvantages of creating an AMA super PAC. Based on a comprehensive review by a preeminent federal election law expert and polling of AMA member and nonmember physicians, the

report concluded that there was no precedent for professional organizations establishing a super PAC that would have the potential to meaningfully impact federal elections and there was virtually no interest by physicians in making monetary contributions to or otherwise supporting an AMA super PAC. The report recommended that the use of AMA corporate funds for a super PAC was not fiscally responsible and should not be pursued due to the lack of a reliable and sustainable outside source of funding and the absence of interest among AMA member and non-member physicians to support a super PAC. During testimony at the 2016 Annual Meeting, the original resolution sponsors asked that the Board study a new proposal that the AMA create and fund with AMA reserves an “AMA Fund for Physician Candidates.” The proposed fund would be dedicated to conducting federal independent expenditures (political advertising) solely on behalf of qualifying physician candidates for the U.S. House of Representatives and Senate. Based on this deviation from the original resolution, this new proposal was referred to the Board for another study.

DISCUSSION

The key points in the position paper submitted by the sponsors of the original resolution are summarized as follows:

- A new name for the AMA-sponsored fund, AMA Fund for Physician Candidates, is intended to avoid the negative public perception of super PACs.
- Only positive independent expenditures on behalf of physician candidates in competitive races would be conducted.
- In order to qualify for independent expenditure support, only physician candidates recommended by state medical society PACs and supported by AMPAC would be considered.
- Since the AMA would provide corporate funds for this activity, the sponsors believe AMPAC fundraising and political activities would not be negatively impacted.
- The AMA has a favorable public image which has the potential to positively influence election outcomes.
- Initially, the AMA should allocate \$1 million from corporate reserves for this effort and future contributions should be made on an as-needed basis.
- Although the AMA would be required to pay corporate income tax on treasury funds used for political activity, it should be considered a “cost of doing business” in order for the AMA to participate more vigorously in the political process.

As a nonprofit tax-exempt organization under Section 501(c)(6) of the Internal Revenue Code, the AMA would be taxed on expenditures of its corporate treasury funds for political activity, including independent expenditures supporting physician candidates. The AMA would be taxed on the lesser amount of: (a) the AMA’s net investment income for the tax year in which political expenditures are made; or (b) the aggregate amount of political expenditures made during the tax year. The taxable amount is subject to the highest corporate income tax rate, currently 35 percent. We have not found an example of any similar 501(c)(6) professional association that has expended its corporate treasury funds in this manner and subjected itself to such tax liability.

If the AMA were to create an independent expenditure fund, it would have to be registered with the Federal Election Commission (FEC) as an Independent Expenditure-Only Political Committee (IEOPC), commonly referred to as a “super PAC.” All receipts and expenditures would need to be regularly reported to the FEC. As a 501(c)(6) organization, AMA’s spending on political activity cannot be the “primary purpose and activities” of the organization. Also, election campaign related expenditures must be accounted for in the calculation of the portion of members’ AMA dues that are nondeductible because they were spent for lobbying and political purposes.

There are two other possibilities for the AMA to fund independent expenditures in federal elections with corporate funds but neither is a suitable option. The AMA could create a related 501(c)(4) but the Internal Revenue Code requires that it would need to be organized and operated primarily for social welfare purposes, not political activity. Such an entity would not need to register with the FEC as a super PAC but it would be subject to the corporate income tax rate to the extent that it makes expenditures directly promoting the election or defeat of a candidate. A second avenue for political involvement using corporate funds would be to create a Section 527 political organization formed under the Internal Revenue Code. Section 527s are often described as “dark money” groups because they do not disclose their revenue sources and expenditures to the FEC. However, because they are not under the jurisdiction of the FEC, they may not expressly advocate for the election or defeat of specific federal candidates.

As was noted in previous Board reports, most super PACs are financed through personal contributions from a small handful of extremely wealthy individuals. These PACs are normally highly partisan and are often focused on single issues or created to benefit specific candidates. We have identified only two 501(c)(6) professional associations that have created super PACs; however, neither PAC is funded by corporate contributions from its parent organization.

While super PACs continue to play an outsized role in elections—spending on federal campaigns reported to the FEC for the 2016 election cycle was \$1.1 billion—their effectiveness is not universally accepted. Super PAC contributions to opposing candidates in most competitive races tend to cancel out each other. For example, super PAC spending in U.S. Senate races this cycle totaled \$500 million, including \$52 million in their efforts to influence the outcome of the Nevada Senate race involving Dr. Joe Heck. Even though super PAC expenditures favoring Dr. Heck exceeded those on behalf of his opponent, he lost that election.

The AMA commissioned a poll of AMA member and non-member physicians last year to assess physician support for the creation of an AMA super PAC and their willingness to contribute to it. As noted in Board of Trustees Report 16-A-16, 87 percent of the respondents said they would not be likely to donate to an AMA super PAC. The reasons they cited for their lack of interest were that the super PAC might contribute to candidates they do not personally support; they do not agree with the concept of super PACs; they are not politically inclined or in general do not make political contributions; or their political views do not align with those of the AMA. The general finding from that poll was that there was little to no interest by either AMA or non-member physicians in making monetary contributions to or otherwise supporting an AMA-established super PAC.

In late February of this year, the AMA sponsored a poll of AMA member physicians to gauge reaction to the AMA creating and using corporate funds for partisan political activity. The top messages we tested in support of establishing this fund for this purpose were that organized medicine needs more champions in Congress and that the fund would help make sure physician candidates have the financial support they need, especially in highly competitive races. The top arguments in opposition to the fund were that the use of AMA corporate funds for election activities could alienate some AMA members who might object from a partisan or ethical perspective and that there would be significant tax implications to the AMA.

There was initial support for a “Fund for Physician Candidates” when it was not identified as a super PAC. A majority of respondents (65 percent) expressed support; however, the intensity of support was extremely low. Only 11 percent “strongly” supported the creation of a fund, while a majority (54 percent) said they “only somewhat” supported it. When AMA members learned that the fund would be a super PAC funded by AMA corporate funds, opposition to the establishment of this fund increased and its support decreased. Support for the fund fell to less than a majority (47 percent) and opposition to it rose to 32 percent.

RECOMMENDATION

While the Board fully understands the goal of enhancing the AMA’s advocacy efforts in Congress, we continue to have significant concerns about expending corporate treasury funds for the purpose of influencing federal elections and the reaction this activity might have among portions of our AMA membership due to their own personal partisan and ethical viewpoints. As noted earlier, the results of our two physician polls conducted in 2016 and earlier this year indicate little support for the creation of an AMA super PAC.

Therefore, the Board of Trustees recommends that the following be adopted in lieu of Resolution 606-I-14 and that the remainder of this report be filed:

That our American Medical Association not use AMA corporate treasury funds to engage in partisan political activity.

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

Reference committee hearing: see report of [Reference Committee B](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 239
REMAINDER OF REPORT FILED
See Policies H-478.997 and D-478.968**

INTRODUCTION

At the 2016 Annual Meeting, The House of Delegates (HOD) adopted Policy D-478.970, “Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging,” which asks that:

Our American Medical Association study the medicolegal implications of text messaging and other non-HIPAA-compliant electronic messaging between physicians, patients, and members of the health care team, with report back at the 2017 Annual Meeting.

Our AMA develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.

This report outlines federal requirements for text messaging and other electronic messaging communications that convey patient information. It notes that using such technology is not barred by federal privacy and security laws but entails certain risks that should be weighed and considered. The report also emphasizes the importance of patient consent when using these tools and highlights ongoing efforts to clarify appropriate uses of communicating via text or electronic messaging.

BACKGROUND

As technology has developed, communication by text and other electronic messaging has become extremely common. Physicians, other health care workers and patients are part of this trend and are using these tools more and more often. For example, one study found that the majority of physicians use text messaging, and that it was the preferred form of communication among members of the health care team for patient related care.¹

Using electronic messaging can offer numerous advantages for clinical care since it is usually fast and efficient. Many patients also value the ability to communicate with their health care providers via text due to their access to and familiarity with a cell phone’s texting capabilities since texting is readily available on their cell phones. Patients now ask that their health information be sent to them in this form.

Many health professionals also prefer to communicate with their co-workers via text rather than paging. As a comparison, one-way paging does not allow a recipient to directly respond to a message’s sender. While some clinicians have access to two-way paging, this technology still requires additional steps or use of an entirely separate device that is in addition to the health care worker’s phone. Further, since pagers generally do not include address book functionality, the risk of sending a paged message to an unintended recipient is greatly increased compared to using a cell phone’s address book to select a text message recipient.

Texting and other forms of electronic messaging, however, have specific and unique risks that should be considered before being used. For example, pagers typically do not store any data directly on the paging device whereas the information in texts is stored and typically remains accessible on a person’s phone. Text messages often can also be viewed on a phone’s home screen, allowing anyone near the phone to see the messages without the need to enter a password. Texting networks also have less broadcast power than pagers, which make the signals less reliable, especially in cases of emergencies.

Physicians and patients are often not aware of the full risks associated when communicating via text or electronic messaging. Many are also confused about what is or is not permitted by law, what limitations are placed on these

forms of communication, and how to manage the unique risks when using texting or electronic messaging. The following sections of this report provide background on the legal requirements and other considerations that may be relevant when using texting or electronic messaging to communicate with patients or across the health care team.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PROTECTIONS

Safeguards for text or electronic messaging to patients and the health care team

Guidance on the use of text and electronic messaging has typically advised against their use because of privacy and security concerns, including potential HIPAA violations. Caution was recommended because of the lack of encryption, the fact that the vendor/wireless carrier can store text messages, and the inability for the sender to know with certainty that the message is received by the intended recipient.² Ultimately, unencrypted text messaging, without additional safeguards, continues to pose these risks and is generally not recommended for communicating Protected Health Information (PHI). PHI is defined as information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual and relates to:

- the individual's past, present, or future physical or mental health or condition;
- the provision of health care to the individual; or
- the past, present, or future payment for the provision of health care to the individual.³

Under HIPAA, messages that contain PHI, whether sent among members of the health care team or to patients, generally require sufficient safeguards to ensure the confidentiality, integrity, and security of the information.⁴ New advances in technology, however, have addressed some of these concerns and have created forms of encrypted texts and electronic messaging. The U.S. Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) directly addressed texting in a frequently asked question (FAQ). In its response, ONC notes that physicians and other providers who plan to use text to communicate PHI with patients or other health care providers should adhere to the HIPAA Security Rule, including performing a risk analysis and utilizing a secure communication platform on approved mobile devices.⁵

To implement appropriate safeguards, physicians and other providers should consult with legal counsel and information technology security experts to understand their obligations under the HIPAA Security Rule. In general terms, HIPAA requires that physicians and other covered entities conduct a risk assessment to determine potential privacy and security vulnerabilities when communicating PHI electronically.⁶ This assessment does not prescribe specific actions that must be taken to secure information. Instead, practices must consider their resources and capabilities to take reasonable and appropriate precautions when communicating via text or electronic messaging.⁷ To provide additional clarity, HHS has developed specific security and privacy guidance on when and how to use mobile phones while still maintaining appropriate privacy and security standards.⁸

Following the Security Rule, however, is only the first step in ensuring that text messaging can be used when communicating PHI. Other considerations that the physician and practice should evaluate when deciding if texting is appropriate include patient consent and liability risks. AMA policy provides additional general guidance on these issues and is discussed in more detail below.

Emailing, texting and electronic messaging when the patient has consented or initiated communications

While using a secure texting platform is generally considered a best practice to communicate PHI, there may be circumstances where a patient asks for or initiates a non-secure text. The HIPAA Privacy Rule provides a patient with the right to request and have a health care provider communicate with him or her by the patient's preferred means, if it is reasonable for the provider to do so.⁹ HHS clarified that this right allows a patient to request that a physician communicate with him or her electronically and that the physician may agree to the patient's request if the physician uses reasonable safeguards to avoid unintentional disclosures.¹⁰

HHS further explained that physicians are permitted to send information via unencrypted emails if they have advised the individual of the risk and the recipient still prefers this method of communication.¹¹ Such a warning may allow the patient to weigh the risk of unintentional disclosure against the ease of using an unsecured form of communication. HHS clarified that it does not expect the physician or covered entity to educate the patient about encryption or information security but merely explain that there is some level of risk of exposure to a third party. If

the patient is notified of this risk, and still consents to using this manner of communication, covered entities mitigate the risk of unauthorized access of the PHI. Furthermore, the covered entity is not responsible for safeguarding the information once it is delivered to the individual.¹² It is recommended that a physician obtain written consent prior to initiating communications with a patient.

If a patient initiates communications with a provider using email, HHS noted that the health care provider can assume (unless the patient has explicitly stated otherwise) that this form of communication is acceptable to the individual.¹³ If the provider feels the patient may not be aware of the possible risks of using unencrypted communication, or has concerns about potential liability, the provider can alert the patient of those risks, and let the patient decide whether to continue the communications.¹⁴

TELEPHONE CONSUMER PROTECTION ACT (TCPA)

The TCPA also places requirements on certain text messages or calls. Specifically, the TCPA requires prior opt-in written consent for the delivery of marketing text messages and prior opt-in oral consent for the delivery of non-marketing or informational text messages.¹⁵ The TCPA also governs the use of an autodialer (defined broadly to include any device that is *capable* of randomly dialing a number without human intervention, which has been interpreted to cover most desk phones and smart phones) and on the use of prerecorded voice technologies when calling cell phones. Prior written opt-in consent is required for placing an autodialed or prerecorded marketing call to a cell phone; prior opt-in oral consent is required for placing an autodialed or prerecorded informational call to a cell phone. The TCPA also imposes requirements on the use of prerecorded technologies to landlines.¹⁶ For more details about the TCPA requirements, including the do-not-contact and consent provisions, time-of-day restrictions, opt-out requirements, and other restrictions, entities can review the materials on the law available from the Federal Communications Commission. Please note that states impose separate and often superseding restrictions on the use of autodialing and prerecorded technologies and placement of telemarketing calls.

INSTITUTIONAL POLICIES & LOCAL RESTRICTIONS

While HIPAA allows the use of text and electronic communications in compliance with the HIPAA requirements as described above, hospital policies, institutional guidance, and state or local laws may ban or place additional limitations on the use of these communication tools. Such additional restrictions are unique to each facility and jurisdiction and must be considered when communicating with either patients or among health care team members. These laws and policies may require additional protections for certain types of patient information (e.g., substance abuse, mental health). They may also require that physicians undergo training, use certain devices, follow procedures in case of a potential breach, and may impose penalties or disciplinary actions.

As an example of institutional guidelines, The Joint Commission has repeatedly changed its policy with respect to text messaging. In its most recent guidance, issued in December 2016, The Joint Commission concluded that all health care organizations should have policies prohibiting the use of unsecured text messaging for communicating PHI. Furthermore, even the use of secured text is not permitted for orders.¹⁷ Physicians should therefore ensure that they consider institutional policies as well as local laws before communicating via text and electronic messaging, even when messages do not contain PHI.

GUIDANCE ON TEXT MESSAGING AND ELECTRONIC COMMUNICATIONS

To help guide physicians and other providers on the appropriate use of text and electronic messaging, HHS has developed several tools, including a [website](#) devoted to appropriately securing mobile devices.¹⁸ This guidance, which is available for free, includes tips on how to develop mobile device policies, advice on how to secure and protect health information, a list of FAQs, and instructional videos. In addition, the HHS Office of Civil Rights [website](#) contains a number of tools related to HIPAA that help physicians conduct risk assessments and other actions required to protect electronically-sent PHI. The AMA anticipates that additional guidance on texting will be available later this year to provide greater clarity on how HIPAA applies to this form of communication.

As instructed by the second section of Policy D-478.970, the AMA is also developing patient-oriented educational materials about text and electronic messaging. The AMA anticipates publishing this education information via AMA Wire later this year.

CURRENT AMA POLICY

As mentioned previously, additional considerations beyond federal and local laws should also be considered before texting either with the health care team or directly with patients. These concerns include privacy, liability, confidentiality, as well as ways to mitigate potential risks. Our AMA has adopted Policy, H-478.997, “Guidelines for Patient-Physician Electronic Mail” on communicating with patients via e-mail that would also guide text and other electronic communications. Specifically, this policy highlights the importance of informing patients about privacy issues when using these modes of communication and encourages use of a patient-clinician agreement to ensure informed consent when communicating in this manner. It also notes precautions that should be taken when using e-mail that would equally apply in the context of text messaging, such as avoiding group messaging where recipients are visible to each other.

More general guidance on how to manage communications and disclosure of patient information to ensure privacy and confidentiality is included in AMA Policies [H-140.989](#), [H-315.983](#), [H-315.978](#), and [H-320.994](#). These policies note that holders of health record information should be responsible for reasonable security measures and the importance of patient consent and education when disclosing and protecting patient information.

CONCLUSION

When communicating PHI with patients and amongst the health care team, HIPAA allows health care providers to text utilizing a secure communication platform if providers comply with the HIPAA Privacy and Security Rule and other applicable federal and local laws. AMA policy, however, notes physicians should also consider institutional, local and other requirements, patient consent, and liability risks before engaging in this practice.

RECOMMENDATION

The Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed.

1. That AMA Policy H-478.997 be amended by addition to read as follows:

Policy H-478.997, “Guidelines for Patient-Physician Electronic Mail and Text Messaging”

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient’s care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee’s usual business hours and during addressee’s vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.

- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- (o) Explain to patients that their messages should be concise.
- (p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- (q) Remind patients when they do not adhere to the guidelines.
- (r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

- (a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
 - (b) Terms in communication guidelines (stated above).
 - (c) Provide instructions for when and how to convert to phone calls and office visits.
 - (d) Describe security mechanisms in place.
 - (e) Hold harmless the health care institution for information loss due to technical failures.
 - (f) Waive encryption requirement, if any, at patient's insistence.
 - (g) Describe security mechanisms in place including:
 - (h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
 - (i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
 - (j) Never using patient's e-mail address in a marketing scheme.
 - (k) Not sharing professional e-mail accounts with family members.
 - (l) Not using unencrypted wireless communications with patient-identifiable information.
 - (m) Double-checking all "To" fields prior to sending messages.
 - (n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
 - (o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

(4) The policies and procedures for email be applied to text and electronic messaging using a secure communication platform, where appropriate.

2. That our American Medical Association work with the Office of Civil Rights to develop guidance on text messaging to facilitate the appropriate and safe use of this technology when communicating patient information.

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APPENDIX – CURRENT AMA POLICY

Policy H-478.997, “Guidelines for Patient-Physician Electronic Mail”

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient’s care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee’s usual business hours and during addressee’s vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.

- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- (o) Explain to patients that their messages should be concise.
- (p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- (q) Remind patients when they do not adhere to the guidelines.
- (r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

- (a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
 - (b) Terms in communication guidelines (stated above).
 - (c) Provide instructions for when and how to convert to phone calls and office visits.
 - (d) Describe security mechanisms in place.
 - (e) Hold harmless the health care institution for information loss due to technical failures.
 - (f) Waive encryption requirement, if any, at patient's insistence.
 - (g) Describe security mechanisms in place including:
 - (h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
 - (i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
 - (j) Never using patient's e-mail address in a marketing scheme.
 - (k) Not sharing professional e-mail accounts with family members.
 - (l) Not using unencrypted wireless communications with patient-identifiable information.
 - (m) Double-checking all "To" fields prior to sending messages.
 - (n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
 - (o) Commit policy decisions to writing and electronic form.
- (2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
- (3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

Policy H-140.989, "Informed Consent and Decision-Making in Health Care"

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient. (2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient. (3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy. (4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others. (5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached. (6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people. (7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.

Policy H-315.983, "Patient Privacy and Confidentiality"

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. 2. Our AMA affirms: (a) that physicians and

medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures. 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

Policy H-315.978, "Privacy and Confidentiality"

Our AMA policy is that where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (1) the information should have identifying information stripped from it or (2) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity.

Policy H-320.994, “Confidentiality”

Our AMA believes that: (1) there has been an erosion of the confidential relationships between the patient and health professional, which has resulted from growing outside demands for the information shared in this relationship for the purpose of patient care; (2) there is a need to sensitize the public to the intrusions into confidential medical information which can result from increased demands for accountability - in substantiating health insurance claims, in litigation, and in medical care evaluation; (3) much of the erosion has emanated from the public, and properly so; however, an over-emphasis on society’s right to know, at the expense of the individual’s right to privacy and confidentiality, has resulted and a better balance is needed; (4) one important contribution to restoring such balance would be greater education of patients and the public as to the full range of purposes for which confidential information is used, the policies governing the release of such information, and the individual’s rights with respect thereto.

Policy H-315.989, “Confidentiality of Computerized Patient Records”

The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.

12. UNFORESEEN CONSEQUENCES OF CORE MEASURES (RESOLUTION 717-A-16)

Reference committee hearing: see report of [Reference Committee G](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
(RESOLUTION 717-A-16 NOT ADOPTED)
REMAINDER OF REPORT FILED**

See Policy H-450.926

At the 2016 Annual Meeting, the House of Delegates (HOD) referred Resolution 717-A-16, “Unforeseen Consequences of Core Measures,” for report back at the 2017 Annual Meeting. This resolution was introduced by the Young Physicians Section and asked that:

Our AMA call for the immediate suspension of the SEP-1 core measure and any financial incentives or penalties relating to compliance with it;

Our AMA strongly discourage the implementation of further protocols, core measures, or directives concerning the care of patients in the outpatient or inpatient setting without structured trials designed to identify unforeseen costs and potential patient harms;

Our AMA strongly discourage the implementation of indiscriminant and not medically indicated screening or testing for “pre-existing” infection in patients in order to avoid financial penalties; and

Our AMA supports any physician who refuses to perform testing or treatment that they feel is not medically indicated or potentially harmful to patients.

BACKGROUND

At the 2016 Interim Meeting, the HOD referred for decision Resolution 811-I-16, “Opposition to Centers for Medicare & Medicaid Services (CMS) Mandating Treatment Expectations and Practicing Medicine.” This resolution was introduced by the Texas Delegation and asks that:

Our AMA oppose CMS creating mandatory standards of care that may potentially harm patients, disrupt the patient-physician relationship, and fail to recognize the importance of appropriate physician assessment, evidence-based medicine and goal directed care of individual patients; communicate to hospitals that some CMS mandatory standards of care do not recognize appropriate physician treatment and may cause unnecessary harm to patients and communicate to members, state and specialty societies, and the public the dangers of CMS’ quality indicators potentially harming the patient-physician relationship.

Given that there is significant overlap between Resolutions 811-I-16 and 717-A-16, at the 2016 Interim meeting members from the Board of Trustees (BOT), Council on Medical Service, and Council on Legislation noted that a resolution addressing the unintended consequences of the Hospital Inpatient Quality Reporting (IQR) program measures was referred at the 2016 Annual Meeting. Therefore, a report on the issues raised in Resolution 811-I-16 was already being developed. However, several speakers noted the urgency of this resolution since implementation of the problematic measure has already begun. There were calls to refer Resolution 811-I-16 for decision, since members felt action might need to be taken prior to the 2017 Annual Meeting. Therefore, Resolution 811-I-16 was referred for decision even though this report was already in development.

In addition, since the time Resolution 811-I-16 and 717-A-16 were introduced, several changes have been made to the severe sepsis and septic shock measure which addresses the issues that were referenced in the resolutions. Therefore, the BOT acted on Resolution 811-I-16 in February 2017 by adopting the below general policy in lieu of Resolution 811-I-16 (Policy H-450.927, “Development of Quality Measures with Appropriate Exclusions and Review Processes” and Policy D-450-953, “Development of Quality Measures with Appropriate Exclusions and Review Processes”):

Our AMA advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.

Our AMA advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

Our AMA provide input on the Severe Sepsis and Sepsis Shock: Management Bundle measure during the National Quality Forum’s (NQF) review of the measure in 2017, and ask the Centers for Medicare & Medicaid Services to redesign the measure.

Given that general policy has already been issued, and the specific issues addressed in this resolution have been resolved, no additional action is needed. This report provides information on the Hospital IQR program, including specific analysis of the sepsis measure.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 mandated the Hospital Inpatient Quality Reporting program. The statute authorized CMS to pay hospitals that successfully report designated quality measures a higher annual payment update. Initially, the MMA provided a 0.4 percentage point reduction in the annual market basket update for hospitals that did not successfully report the required quality measures. Section 5001(a) of the Deficit Reduction Act of 2005 provided new requirements for the Hospital IQR program and increased the possible payment reduction to two percentage points. Section 1886(d) of the Social Security Act requires CMS to make data collected under the Hospital IQR program available to the public on Hospital Compare.

Measures included in the Hospital IQR program are designed to standardize practices among hospitals and improve patients’ quality of care. The measures range from reporting whether stroke patients with an abnormal heartbeat received anti-coagulation therapy to whether a heart failure patient received proper discharge instructions.

SEPSIS

Addressing the issue of appropriate care for patients with severe sepsis and septic shock is vital to improving health care quality and reducing health care costs. Sepsis represents the most expensive condition treated in United States hospitals, and was the second most common principal diagnosis for hospitalization in the United States in 2013.¹ In addition, the Agency for Healthcare Research and Quality (AHRQ) found that the sepsis mortality rate is more than eight times higher than mortality rates among patients admitted for other conditions. From 1999 to 2014, the annual number of reported sepsis-related deaths (primary and secondary diagnosis combined) increased 31 percent, from 139,086 in 1999 to 182,242 in 2014.²

Severe Sepsis and Septic Shock: Management Bundle

The “whereas” clauses in Resolution 811-I-16 and Resolution 717-A-16 both discuss physicians’ concerns with a particular Hospital IQR program measure, Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) (SEP-1), NQF 0500. The SEP-1 measure was included as a Hospital IQR program measure on October 1, 2015, as one of the 2015 Hospital IQR program measures that will apply to Fiscal Year 2017 payment determinations for hospitals.

Measure Description

The SEP-1 composite process-of-care measure focuses on adults ages 18 and older with a diagnosis of severe sepsis or septic shock. SEP-1 assesses the timely measurement of lactate levels, the timely collection of blood cultures, the administration of broad spectrum antibiotics, fluid resuscitation, vasopressor administration, timely reassessment of volume status and tissue perfusion, and a repeat lactate measurement. The measure calculates the percentage of patients with severe sepsis or septic shock for whom all of the relevant and recommended bundles have been completed, within the required timeframe, as a single composite measure. All bundles must be completed in order for a case to pass the measure. Results of the SEP-1 measure are then reported as an aggregate rate generated from all the cases assessed and reported as a proportion. Hospitals with five or fewer discharges (both Medicare and non-Medicare combined) in a measure set (SEP-1) within a quarter are not required to submit patient-level data for that measure set for that quarter.

The intent of the SEP-1 measure is an effort to lower complication and mortality rates, while making sepsis care more affordable by focusing on early intervention. However, the new measure has created some controversy within the medical community, which is referenced in Resolutions 811-I-16 and 717-A-16. Specifically, these two resolutions raise concerns that SEP-1 fails to adequately account for individual patient circumstances. Physicians have reported that while there are benefits for some patients to receive the treatments required by this measure, there are also numerous situations where patients should be exempt from receiving this treatment. Many of these concerns have been addressed in later versions of measure specifications and release notes.

Measure Calculation

The denominator of the SEP-1 measure includes patients with an inpatient hospital stay, ages 18 and older, with an ICD-10-CM principal or other diagnosis code of sepsis, severe sepsis, or septic shock. The numerator for this measure includes patients from the denominator who meet the requirements and have the characteristics listed below:

- Within three hours of presenting with severe sepsis: their lactate levels were measured, their blood cultures were obtained before antibiotics were administered, and they were given broad spectrum antibiotics.
- Within six hours of presenting with severe sepsis, the patients’ lactate level was drawn again if the initial lactate level was elevated.
- Within three hours of presenting with septic shock, the patients’ received 30 ml/kg of crystalloid fluids.
- And only if hypotension does not respond to the initial fluid resuscitation within six hours of presentation of septic shock, then vasopressors were given.
- And only if hypotension persists after fluid administration of the initial lactate level is ≥ 4 mmol/L, the volume status was reassessed, and tissue perfusion was performed, within six hours of presentation of septic shock.

Currently the following patients are excluded from SEP-1:

- Severe sepsis is not present;
- Directive for comfort care or palliative care within three hours of presentation of severe sepsis;
- Directive for comfort care or palliative care within six hours of presentation of septic shock;
- Administrative contraindication to care within six hours of presentation of severe sepsis;
- Administrative contraindication to care within six hours of presentation of septic shock;
- Length of stay greater than 120 days;
- Transfer in from another acute care facility;
- Patients with severe sepsis who are discharged within six hours of presentation;
- Patients with septic shock who are discharged within six hours of presentation;

- Patients receiving intravenous antibiotics for more than 24 hours prior to presentation of severe sepsis; and
- Patients included within a Clinical Trial (Note: This exclusion will be removed from the list in 2018).

Resolutions 811-I-16 and 717-A-16 noted that there were circumstances, in addition to those listed above, which may create issues for physicians attempting to adhere to the SEP-1 measure requirements. Specifically, if a patient has severe systolic dysfunction (LVSD), a physician may determine that treating the patient with the amount of fluids required under the SEP-1 measure would be harmful to the patient, possibly causing fluid overload. Some research shows that this can be harmful to patients with septic shock and increase mortality, and more than 60 percent of patients who present with septic shock have LVSD.^{3,4} If a physician provides the appropriate care to the patient in this circumstance (limiting the fluids), it would impact their ability to comply with the SEP-1 measure.⁵ This concern was addressed in the CMS July through December 2016 measure specification updates. Specifically, the developer added a new element to the measure on “initial hypotension” to better identify patients who should receive crystalloid fluids. The new element should help ensure that physicians will not be penalized for failing to provide fluids to patients for whom those fluids may be harmful in the SEP-1 measure calculation.

In addition, the measure required that blood cultures be completed prior to starting a patient on antibiotics, which is common clinical practice. In some situations, this requirement was problematic, as the Surviving Sepsis Campaign guideline recommendation states “we recommend obtaining appropriate cultures before anti-microbial therapy is initiated if such cultures do not cause significant delay (> 45 minutes) in the start of antimicrobial(s) administration (grade 1C).”⁶ It was possible that if this delay occurred, a physician would have no way to indicate that he or she prioritized giving the patient a broad-spectrum antibiotic over waiting for the cultures to be drawn. Due to these concerns over the requirement for blood cultures prior to administering antibiotics, in the updated release for 2017 specification release notes from CMS, an additional data element was added that allows a physician to document if there was an acceptable delay in drawing blood cultures.⁷ This new element alleviates physicians’ concerns and illustrates that there may be times when prioritizing the administration of antibiotics over the blood culture is appropriate.

Physicians also questioned whether the definitions that were used to define the population of interest (denominator) in this measure were too broadly defined. Specifically, with the inclusion of organ dysfunction in the severe sepsis definition, patients with end-stage renal disease or cirrhosis may be counted in the denominator.⁸ This inclusion of false positives paired with the inability to exclude patients beyond what is currently outlined could have had unintended negative consequences and directly affected the validity of the measure. In the 2017 updated specification release notes, CMS added an additional data element requiring documentation of severe sepsis by the physician. This requirement addresses the concern that the measure may not be defined precisely enough to capture the correct patients and allows individual patient circumstances to be considered.

Current NQF Review

SEP-1 was developed by the Henry Ford Health System in collaboration with leadership and representatives from the Society of Critical Care Medicine and the Infectious Diseases Society of America based on the Surviving Sepsis Campaign guidelines.⁹ Some changes have been made to the measure based on new randomized controlled trial data, such as the ProCESS trial. The results of this trial led to NQF’s ad hoc review of the measure in 2013. SEP-1 is also currently undergoing maintenance review of its endorsement status with NQF as part of the Infectious Disease Project 2016-2017. Outside stakeholders, such as the AMA, will have the opportunity to provide input to NQF during this review process.

CONCLUSION

Many of the specific concerns noted in Resolution 717-A-16 have been resolved in later updates to the SEP-1 measure specifications and release notes. In addition, Resolution 717-A-16 should not be adopted on the grounds that the Board of Trustees already acted on this issue in February 2017 by adopting a substitute resolution in lieu of Resolution 811-I-16 which states:

Our AMA advocate for quality measures, including those in the Hospital Inpatient Quality Reporting program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.

Our AMA advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

Our AMA provide input on the Severe Sepsis and Sepsis Shock: Management Bundle measure during National Quality Forum's (NQF) review of the measure in 2017, and ask CMS to redesign the measure.

Resolution 717-A-16 has already been addressed by the Board of Trustees at the direction of the House of Delegates through action on Resolution 811-I-16. Therefore, the Board of Trustees recommends that Resolution 717-A-16 not be adopted.

RECOMMENDATION

The Board of Trustees recommends that the following recommendations be adopted and the remainder of this report be filed.

1. That resolution 717-A-16 not be adopted; and
2. That our American Medical Association discourage the implementation of indiscriminant and not medically indicated screening or testing for "pre-existing" infection in patients in order to avoid penalties.

REFERENCES

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4. Boyd et al (2011) *Fluid resuscitation in septic shock: A positive fluid balance and elevated central venous pressure are associated with increased mortality*. Critical Care Medicine 39(2): 259-265;
5. Kelm et al (2015). *Fluid overload in patients with severe sepsis and septic shock treated with early goal-directed therapy is associated with increased acute need for fluid-related medical interventions and hospital death*. Shock 43(1): 68-73; Pulido et al (2012). *Clinical spectrum, frequency, and significance of myocardial dysfunction in severe sepsis and septic shock*. Mayo Clinic Proceedings 87(7): 620-628.
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7. Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.2a. Available at file:///C:/Users/amcglone/Downloads/SEP_1_Addl_Notes_v5_2a.pdf. Accessed February 23, 2017.
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9. CMS Fact Sheet SEP-1: Early Management Bundle, Severe Sepsis/Septic Shock.

EXISTING AMA POLICY

AMA Code of Medical Ethics, Chapter 1, Opinion 1.1.6 – Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable. While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

- (a) Keeping current with best care practices and maintaining professional competence.
- (b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
- (c) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.
- (d) Demonstrating commitment to develop, implement, and disseminate appropriate, well- defined quality and performance improvement measures in their daily practice.
- (e) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

Policy D-225.977, "Physician Independence and Self-Governance"

Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care

organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.

13. CLOSING GAPS IN PRESCRIPTION DRUG MONITORING PROGRAMS (RESOLUTION 232-A-16)

Reference committee hearing: see report of [Reference Committee B](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 232-A-16
REMAINDER OF REPORT FILED**
See Policy H-95.947

INTRODUCTION

At the 2016 Annual Meeting, the House of Delegates referred Resolution 232-A-16, “Closing Gaps in Prescription Drug Monitoring Programs,” introduced by the Alabama Delegation, which asked:

That our American Medical Association advocate for the inclusion of all controlled substance prescriptions, regardless of their private, public, military or governmental source, in the reporting requirements for Prescription Drug Monitoring Programs (PDMP); and

That our AMA advocate for the inclusion of all controlled substances administered or dispensed by opioid treatment programs in the reporting requirements for Prescription Drug Monitoring Programs (PDMP).

During reference committee hearings considerable testimony supported using PDMPs to inform physicians’ decision making when considering whether to prescribe controlled substances. Many commented that when PDMPs contain relevant, timely information that is available at the point of care, PDMPs can provide helpful information. Testimony was clear, however, that many state PDMPs are less than optimal for a variety of reasons, including that information from opioid treatment providers (OTPs), the Veterans Health Administration (VHA) and other sources are not always included in PDMPs.

The reference committee agreed that PDMPs can be most helpful when they contain all relevant information. Testimony also raised important issues regarding patient privacy, including that OTPs must comply with the strict privacy requirements under 42 CFR Part 2 governing disclosure of patient records, and that state PDMPs may not all meet those requirements. This report provides an update on PDMP functionality, relevant state legislative issues, and makes a number of recommendations.

DISCUSSION

Physician use of PDMPs continues to increase. In fact, an AMA survey of state PDMP administrators found that queries by health care professionals to state PDMPs increased from 60.7 million in 2014 to more than 85 million in 2015—a 40 percent increase.¹ Interestingly, some of the largest increases were seen in states that did not mandate prescribers to check a PDMP. This included California, which saw an increase in use from 3.6 million in 2014 to 6.2 million in 2015; Florida, which saw an increase from 1.5 million in 2014 to 4.1 million in 2015; and Oklahoma, which saw an increase from 1.1 million in 2014 to 2.9 million in 2015. California and Oklahoma have since passed mandates for prescribers to check the PDMP under certain circumstances, and other states currently are considering new mandates requiring use of the PDMP.

One reason for these increases is the fact that mandates to check PDMPs have been enacted in many states in recent state legislative sessions. At the same time, the technology supporting PDMPs has improved in many states, including the development of more readable interfaces, more relevant information being provided on screen, and increased speed of accessing the PDMP itself. While these improvements may not reflect every practice setting or physician’s experience, the trend is generally positive in terms of increased physician use of PDMPs. The Board notes, however, that it remains inconclusive whether or how the new mandates have reduced opioid related mortality or improved pain care on a broad scale.

Regarding Resolution 232-A-16, two of the important issues with respect to the data contained in a PDMP are: (1) the substances monitored by a PDMP; and (2) the frequency of data entered into the PDMP. According to the National Alliance for Model State Drug Laws,² 14 states monitor Schedule II-IV Controlled Substances, while the rest of the states monitor Schedule II-V Controlled Substances. With respect to the frequency of pharmacies and other dispensers reporting data to the PDMP,³ the range is between “real time” at the point of dispensing to monthly reporting. Thirty-two states and the District of Columbia have a 24-hour reporting requirement.

Addressing the merits of whether a state should include all controlled substances or only Schedule II-IV raises multiple issues. As noted above, increased use of PDMPs is generally viewed as a positive trend in terms of physicians seeking more information on which to make more informed prescribing decisions. Yet, those increases have occurred in “mandate” and “non-mandate” states as well as states with requirements to check for all controlled substances and for only Schedule II-IV. To better understand the outcomes of including different schedules of controlled substances in a state PDMP, and to help better inform AMA advocacy, your Board recommends a careful review of the literature and outcomes that PDMPs have on opioid-related mortality, treatment decisions, pain care, and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse (Task Force).

The benefits to such a review include that this review would likely be one of the first of its kind to be carried out by physician organizations. With some states now looking to only require a check of the PDMP for prescriptions for opioids and benzodiazepines,⁴ and other states considering various permutations of when to check a PDMP – and what to check it for – the Board recommends these decisions be informed by data. Compiling this data will afford AMA the opportunity to provide the Federation and policymakers with objective data on which further decisions can be made.

In addition, available information suggests that few U.S. Department of Veterans Affairs (VA) pharmacies report information to the state PDMP.⁵ This runs counter to trends for states to require real time data entry by dispensers. In recent history, only Oklahoma had a 24-hour data entry requirement. As noted above, 32 states and the District of Columbia have a 24 hour/1 business day requirement.⁶ In addition, more than 40 states now are sharing interstate information through the InterConnect program of the National Association of Boards of Pharmacy,⁷ which is supported by the AMA. As state PDMP technology improves, combined with more frequent data reported by state-licensed pharmacies, it would benefit both dispensers and prescribers if information about controlled substances dispensed by VA pharmacies were included in state PDMPs. Therefore the Board recommends that the AMA advocate that VA pharmacies report prescription information required by the state into the respective state PDMP. This will help ensure that physicians and other health care professionals who check a PDMP have the benefit of more comprehensive information from prescriptions dispensed in the state.

Moreover, having VA pharmacies submit information to state PDMPs, would support ongoing VA efforts to have PDMPs serve as clinical support tools. VHA Directive 1306,⁸ issued October 19, 2016, stated:

It is VHA policy that state PDMP databases are queried for VHA patients who are receiving prescriptions for controlled substances as outlined in this policy on a minimum of an annual basis and that the results of queries are documented in the VA medical record. State PDMP databases will be queried prior to initiating therapy with a controlled substance and more often when clinically indicated.

VHA Directive 1306 also notes that a VA health care professional may not be licensed in the state where he or she practices. For the purposes of this report, that means that the health care professional may not be eligible to register for—or use—the state PDMP. This is one of the gaps that could be addressed through state legislation or regulation: specifically authorizing all physicians and other health care professionals to be eligible to register for and authorized to use the state PDMP. Therefore, to help VA physicians use the information in state PDMPs, your Board recommends that VA physicians and other health care professionals employed by the VA be allowed to access the state PDMP in the state in which they are practicing, even if not licensed in the state.

The final issue to address is the role of patient privacy, including that OTPs must comply with the strict privacy requirements under 42 CFR Part 2 governing disclosure of patient records, and that state PDMPs may not all meet those requirements. This was one of the issues that the Substance Abuse and Mental Health Services Administration (SAMHSA) was considering in proposed revisions to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR part 2. The AMA and others commented on the need to ensure a proper balance

between appropriate disclosures to qualified entities and ensuring the privacy and confidentiality of patients with substance use disorders.⁹

In the final rule, SAMHSA specifically declined to “address issues pertaining to e-prescribing and Prescription Drug Monitoring Programs (PDMPs) in the NPRM because they were not ripe for rulemaking at the time due to the state of technology and because the majority of part 2 programs are not prescribing controlled substances electronically.”¹⁰ On one hand, this could mean that SAMHSA did not want to combine discussion of e-prescribing and PDMPs. It also is possible that SAMHSA is monitoring each issue separately. In either case, SAMHSA has not clarified whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs. Therefore, your Board recommends that the AMA seek further clarification on this issue.

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 232-A-16, and that the remainder of the report be filed.

1. That our AMA conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse.
2. That our AMA advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP.
3. That our AMA advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state.
4. That our AMA seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

REFERENCES

1. From January to June 2016, the AMA sent inquiries to every state PDMP administrator. The AMA received data from 42 states; 6 states either did not respond or said they are not able to provide information; and three states (the District of Columbia, Missouri and Pennsylvania) did not have functional PDMPs.
2. National Alliance for Model State Drug Laws, “Substances Monitored by PMP.” <http://www.namsdl.org/library/8D7261F8-E47D-B6A5-DD0CAFA98FEA4846/>
3. National Alliance for Model State Drug Laws, “Frequency of Data Reporting.” <http://www.namsdl.org/library/9ADAAF18-D321-1AE6-90D7B256F05CEDEC/>
4. See for example, legislation in Louisiana and Maryland.
5. See, for example, this state map from the Prescription Drug Monitoring Program Training and Technical Assistance Center at Brandeis University: http://www.pdmpassist.org/pdf/VA_pharmacies_reporting.pdf
6. National Alliance for Model State Drug Laws, “Frequency of Data Reporting” <http://www.namsdl.org/library/9ADAAF18-D321-1AE6-90D7B256F05CEDEC/>
7. National Association of Boards of Pharmacy, PMP InterConnect. Available at: https://nabp.pharmacy/wp-content/uploads/2017/01/PMPMap_-10-25-16.pdf
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9. AMA to Acting Director Kana Enomoto, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. April 11, 2016.
10. Federal Register, Jan. 18, 2017. <https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records>

14. MEDICARE PART B DOUBLE DIPPING (RESOLUTION 209-A-16)

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 209-A-16 REMAINDER OF REPORT FILED

INTRODUCTION

At the 2016 Annual Meeting, the House of Delegates (HOD) referred Resolution 209-A-16, “Medicare Part B Double Dipping,” for report back at the 2017 Annual Meeting. This resolution was introduced by the New York Delegation and asked that:

Our American Medical Association seek legislation to stop the practice by the federal government of deducting Medicare Part B coverage costs from the Social Security checks of retirees, as well as from salaries individuals may earn after they draw on social security benefits.

During the hearing on this resolution, Reference Committee B heard mixed testimony. While there was testimony supportive of the drafter’s intentions, others pointed out that the premise of the resolution that the government is “double dipping,” as described in the whereas clauses, is inaccurate and does not occur. This report discusses the difference between deductions for Medicare Part A from employee paychecks and Medicare Part B premiums from Social Security benefit checks.

BACKGROUND

Medicare is a federal insurance program that pays for health care services for individuals aged 65 and older and certain disabled people. There are four parts: Part A (Hospital Insurance), which covers inpatient hospital services, skilled nursing care, hospice care, and some home health services; Part B (Supplementary Medical Insurance), which covers physician services, outpatient services, and some home health and preventive services; Part C, Medicare Advantage, which is a private plan option; and Part D, which covers outpatient prescription drug benefits. This report will focus on Parts A and B.

Generally, Medicare beneficiaries aged 65 or older are automatically entitled to Part A if they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on their earnings. The Part A trust fund is primarily funded by a 2.9 percent payroll tax on earnings (employees and employers each pay 1.45 percent; those self-employed pay the full 2.9 percent). Employees with annual incomes greater than \$200,000 single/\$250,000 joint are subject to an additional 0.9 percent on income over these amounts. Similar to Social Security taxes, Medicare Part A payroll taxes are based on earnings—i.e., there is no age limit and deductions continue even after an individual becomes eligible for Medicare.

Under Part B, most Medicare beneficiaries pay a monthly premium that is deducted from their monthly Social Security checks. Most of the Part B trust fund (75 percent) is funded through federal government general revenues, while 25 percent is funded by beneficiary premiums. Part B enrollees whose premiums are not deducted from Social Security (or Railroad Retirement, or Civil Service Retirement) monthly benefits, or paid by Medicaid, must pay premiums directly to the Centers for Medicare & Medicaid Services.

DISCUSSION

Resolution 209 asks that our AMA prevent the federal government from deducting Medicare Part B from the salaries individuals may earn after they become eligible to draw on Social Security benefits. However, as explained above, a Medicare beneficiary’s share of the Part B premium is not financed through employee payroll taxes, it generally is deducted from the beneficiary’s Social Security check. Also, to the extent that a Medicare beneficiary continues to work, or returns to work, after becoming eligible for Medicare benefits, the Medicare payroll taxes that are deducted from the beneficiary’s (employee’s) paycheck go to fund the Medicare Part A trust fund, which is used to pay for Medicare Part A benefits.

Resolution 209 states in the whereas clauses that “Medicare Part B is deducted from Social Security their checks,” and “once they return to work, Medicare Part B is also deducted from their paychecks, meaning the government is ‘double dipping.’” However, as discussed above, these paycheck deductions go to fund the Part A trust fund, not the beneficiary’s share of the Part B premium. While it is true that some portion of a beneficiary’s federal income tax would be used to fund the federal government’s general revenue expenditures, which would include funding 75 percent of Medicare Part B premiums, federal income tax deductions do not appear to be the focus of this resolution. The Board, therefore, recommends that Resolution 209-A-16 not be adopted.

RECOMMENDATION

The Board of Trustees recommends that Resolution 209-A-16 not be adopted and the remainder of the report be filed.

15. NO COMPROMISE ON ANTI-FEMALE GENITAL MUTILATION POLICY (RESOLUTION 5-I-16)

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#)

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 5-I-16
REMAINDER OF REPORT FILED**
See Policy H-525.980

Resolution 5-I-16, “No Compromise on Anti-Female Genital Mutilation Policy,” sponsored by M. Zuhdi Jasser, MD (Arizona Delegation), was referred to the Board of Trustees. Resolution 5-I-16 asked:

1. That our American Medical Association reaffirm its policy against female genital mutilation (FGM).
2. That, due to the public debate in 2016 over whether the medical community sanctions a proposed “nicking procedure,” our AMA must further clarify its current position on FGM to explicitly state that our AMA condemns any and all ritual procedures including, but not limited to, “nicking” or “genital alteration” procedures done to the genitals of women and girls.
3. That our AMA, on behalf of the medical community, actively advocate against the practice of FGM in all its forms (including the recently proposed “nicking” and “alteration” procedures) and effectively add the voice of America’s physicians to the voices of many anti-FGM human rights activists and their organizations which advocate for the survivors and victims of FGM.
4. That our AMA partner in this public advocacy with reputable anti-FGM activists and survivors including, but not limited to, Jaha Dukureh of the Tahirih Justice Center, Waris Dirie of Desert Flower Foundation, Layla Hussein of the Maya Center and the Dahlia Project, and Nimco Ali of the Daughters of Eve or Safe Hands for Girls to name a few.
5. That our AMA educate its membership and the American public about the harm of FGM prominently through its website and provide resources about the ethics and medical harm of any and all forms of FGM.

Testimony heard during the reference committee hearing strongly favored the spirit of this resolution. Concerns were stated over the fourth resolve (asking the AMA to partner with specific advocacy groups and survivors of FGM); the author of the resolution agreed that it was not appropriate to state specific groups or people without proper vetting and thus agreed that the fourth resolve should be removed. The reference committee recommended that the remainder of the resolution be worded more strongly, adding specifically that additional policy be created to state that any physician who participates in FGM should be considered unethical. This change was debated on the floor of the House. In addition, questions were raised about what should be considered “mutilation” (cosmetic labial reconstruction and gender reassignment surgery were cited), and concerns were raised regarding the freedom to practice strongly held cultural traditions. Thus, this resolution was referred to the Board of Trustees. This report

summarizes the AMA's position on female genital mutilation (FGM) and compromise procedures, and provides recommendations in response to the resolution.

BACKGROUND

According to the World Health Organization, female genital mutilation (FGM) comprises “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons [1].” The WHO delineates the different methods of FGM into four distinct categories, which are widely accepted and cited:

Type 1: Often referred to as clitoridectomy, this is the partial or total removal of the clitoris, and in very rare cases, only the prepuce.

Type 2: Often referred to as excision, this is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type 3: Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris.

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

These procedures can cause early and late complications. Early complications include bleeding, infection and urinary retention [2,4], though it should be noted that bleeding and infection are risks associated with virtually any procedure. Late and severe complications include urinary complications, scarring, pain, infection, pelvic inflammatory disease, infertility, stillbirth stemming from obstructed labor, postpartum hemorrhage, sexual dysfunction, and death [2-4]. Emerging evidence also suggests that FGM can cause long-term harms to mental health and post-traumatic stress disorder [2,3,10].

Each year, approximately 3.3 million girls worldwide, including 513,000 U.S. women and girls, are at risk of undergoing the procedure [1]. Female genital mutilation is most commonly practiced in Africa, the Middle East, Asia, and among immigrant communities in the US [1]. The procedure is variously seen as a rite of passage, a necessary precursor to marriage, and a way to preserve virginity, femininity and hygiene. Women and girls undergo FGM in response to societal pressure to conform with peers and on the assumption that FGM prevents promiscuity [1,2]. No matter the origin, the practice is widely held to reflect deep-rooted inequality between the sexes and is recognized internationally as a gender-specific violation of human rights [11]. The U.S. government opposes FGM of any type, degree, severity, or motivation for performing it, and it is against the law to practice FGM in the United States [5].

“Nicking”

In 2016, the *Journal of Medical Ethics* published an article that proposed “nicking” as an alternative to FGM that can balance respect for cultural values and traditions with preventing harm. The authors argue that a “nick” on the external female genitalia causes little or no functional harm and should be permitted to avoid more extreme procedures. They state that any society that tolerates male circumcision ought to permit female procedures of comparable harm and policies or campaigns opposing all types of female genital alteration are culturally insensitive. Accordingly, the authors hold that “nicking” is neither gender discrimination (since male circumcision is widely performed) nor a human rights violation [4].

It should be noted that the World Health Organization, UNICEF and the United Nations Population Fund jointly adopted the categorization above, where “nicking” would be considered a Type 4 form of FGM [6,8].

Nicking versus Medical Male Circumcision

Arguments for nicking compare male circumcision as a culturally respectful alternative to FGM [4]. However, this is a false comparison. Male circumcision, of infants, adolescents or adults, may similarly reflect deeply rooted

tradition. Unlike FGM or nicking, medical male circumcision is not rooted in discriminatory ideologies and has health benefits. Since 2007, the World Health Organization and Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended male circumcision for protection against sexually transmitted infections. For instance, the inner foreskin is highly susceptible to HIV infection, and circumcision can reduce the risk of female-to-male sexual transmission of HIV by approximately 60 percent. The procedure does not affect the sex organ or deny a normal sexual life [1].

Despite evidence showing the health benefits of male circumcision, the practice is nonetheless becoming less common in the United States [7], for reasons that are not entirely clear.

CURRENT AMA POLICY

AMA first adopted policy strongly opposing FGM in 1994. In 2012, the House of Delegates amended that policy to address the responsibilities of physicians practicing in the US. In its present form, H-525.980, “Expansion of AMA Policy on Female Genital Mutilation,”

(1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States [12].

NICKING AND COMPROMISE SOLUTIONS

According to the most recent UNICEF data [8], the method of FGM where the female genitals were “cut with flesh removed” (as opposed to cut with no flesh removed or genitals sewn closed) was by far the most common practice among the 25 countries for which data are available. In no country except Eritrea was nicking the most prevalent form of FGM. It should be noted however, that ethnicity within a country also plays a role; in Eritrea, the vaginal openings of 100% and 96% of girls of Hedarib and Afar ethnicities, respectively, were sewn completely shut. Of the six remaining ethnicities identified in this survey for Eritrea, two predominantly practiced nicking and four predominantly practice cutting with flesh removed [8].

There are no readily available data to suggest that permitting nicking would dissuade individuals or families from seeking other, more harmful forms of FGM, even if other forms are legally prohibited. Studying the prevalence of illegal procedures has its own challenges, but to endorse an ethically problematic practice without strong evidence of efficacy is not appropriate. Further, there is little evidence that a nick would satisfy the ritual purpose or physical alterations for which FGM is carried out in the first place. Bodily change is, in many cases, the purpose of the ritual [9]. Verification that the procedure has in fact been performed is expected, whether through functional change (time it takes to urinate), body aesthetics (genitals that are smooth and minimal are seen as more hygienic), or change in sexual satisfaction and drive (in the case of clitoridectomy) [9].

EFFORTS TO ADDRESS FGM

Many organizations worldwide are addressing the issues of FGM. Organizations such as Equality Now and No Peace without Justice promote physician knowledge about FGM worldwide, while others such as The Olmalaika Home create safe houses for girls at risk for FGM in affected countries [13-15].

In the US, it is a felony to perform ritual cutting of any kind on a girl younger than eighteen years of age [2]. In at least one state (Nevada), a person may be prosecuted for the removal of a child from that state for the purpose of having FGM performed on the child [2]. It should also be noted that FGM can be the basis for claiming asylum in the United States [2].

Physicians practicing in the US may encounter patients who have undergone FGM or who request FGM for themselves or a family member. To fulfill their responsibility to provide respectful, culturally sensitive care, as AMA policy provides, physicians must have appropriate medical knowledge and skills and further, must have appropriate language to discuss medical issues with such patients. If asked to perform a type of ritual cut, it is important for the physician, while refusing to do so, to understand that many family members who continue this practice believe that they are doing what is best for their daughters [2].

RECOMMENDATION

In light of the foregoing analysis, which leads to the conclusion that AMA policy in its present form prohibits the practice of “nicking,” the Board of Trustees recommends that Policy H-525.980, “Expansion of AMA Policy on Female Genital Mutilation,” be reaffirmed in lieu of Resolution 5-I-16 and the remainder of this report be filed.

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16. OPPOSE PHYSICIAN GUN GAG RULE POLICY BY TAKING OUR AMA BUSINESS ELSEWHERE (RESOLUTION 604-I-16)

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED (RESOLUTION 604-I-16 NOT ADOPTED) REMAINDER OF REPORT FILED

Resolution 604-I-16, introduced by American Thoracic Society, asked that our American Medical Association (AMA) adopt policy that bars our AMA from holding House of Delegates (HOD) meetings in states that enact physician gun gag laws, and that our AMA contact governors and convention bureaus of states that have enacted physician gun gag rules to inform them that our AMA will no longer hold House of Delegates meetings in their state, until the restrictive physician gun gag rule is repealed or struck down by the courts.

A few states have enacted some form of “gun gag” laws. Currently Montana prohibits physicians from requiring patients to answer questions about guns as a condition of receiving care, Missouri prohibits requiring physicians to ask or record information about patient gun ownership, and Minnesota prohibits the state health programs from collecting data about gun ownership. In addition, “gun gag” bills have been introduced in Iowa and Texas recently. Similar bills have been introduced in Indiana (prohibits requiring physicians to ask and record) and Oklahoma.

Major AMA meetings are not typically held in Montana, Missouri, Minnesota, Iowa, Indiana or Oklahoma and none are currently planned in these states.

While the State of Florida had enacted such a provision (The Firearms Owner’s Privacy Law (FOPL)), that law was overturned by the 11th Circuit Court of Appeals on February 16, 2017. The State of Florida may appeal that decision to the Supreme Court, which may or may not take up that appeal if made. In the meantime, the 2021 Interim Meeting of the House of Delegates is contracted for Orlando, Florida. The cancellation fee for that meeting within two years of the planned date and moving to a new location would be \$424,000. Orlando is being considered for future meetings as well.

Texas is the only other state currently contemplating a gun gag law where the AMA has held major meetings in the past and has viable venues for the future.

DISCUSSION

Often, AMA meeting venues are selected several years in advance to secure locations and begin meeting planning. Among the other considerations, management is directed by current AMA policy to choose hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. For our Interim and Annual meetings, efforts are made to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. In addition, policy directs management to not hold meetings in locations that have exclusionary policies, only in venues that require smoke-free worksites and public places, and to work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping (Policy G-630.140).

By policy the Annual meeting is held each year in Chicago. There are relatively small number of venues that can handle the size and scope of an AMA Interim Meeting without spreading out to multiple hotels and convention center type arrangements which have proven to be less than satisfactory. Management attempts to schedule Interim meetings in variable locations in different regions of our United States and delegates have expressed displeasure with a number of potential venues that have been used in the past.

As evidenced by Florida, it is possible that legislation contrary to AMA policy may be enacted and later repealed or overturned. Conversely, states that have no such legislation at the time a meeting is scheduled, may subsequently introduce or adopt legislation that would be found objectionable by the time the meeting is convened.

The AMA has extensive policy on public health issues as well as multiple other policies impacting the health of our patients and physician practice. While the Board recognizes gun violence as a major public health issue they also believe there are a number of other high priority AMA policies. It would be difficult if not impossible to monitor the compliance of states or cities with AMA policy and move meeting venues accordingly.

In reference committee delegates expressed that if a meeting occurs in a state where laws or statutes are contrary to AMA policy that this provides an opportunity for the AMA to “speak out” on the issue. AMA advocacy activities, working with our local and state medical association partners, do not typically include the selection of venues for our meetings. Convening a meeting at a venue does not endorse the behavior of the hotel, city or state.

CONCLUSION

AMA management considers multiple factors including the directives of the HOD in selecting venues for AMA meetings. Site selection occurs years in advance and typically reservation of select sites requires significant cancellation penalties. Even without consideration of the financial penalty for late cancellation, identifying an available suitable substitute venue becomes increasingly difficult as the meeting date approaches. State and local jurisdictions may at any time adopt legislation or rules that are not aligned with AMA policy including “gun gag” laws.

The Board of Trustees would prefer AMA meetings always be held in cities and states that embrace AMA policy but recognizes the challenges management faces in selecting venues particularly for the House of Delegates meetings. The Board has requested AMA management to keep a vigilant eye on “gun gag” laws and similar types of laws when selecting future meeting locations. AMA management will be closely monitoring the situation in Florida and Texas; should the gag rule gain new life, we will review our AMA’s options.

RECOMMENDATION

Given that the Board and management will be alert to “gun gag” laws and similar types of laws when selecting future meeting sites even without a specific rigid policy, the Board of Trustees recommends that Resolution 604-I-16 not be adopted and the remainder of the report be filed.

17. EQUALITY FOR FUTURE MEETINGS ORGANIZED OR SPONSORED BY THE AMA

Reference committee hearing: see report of [Reference Committee F](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy G-630.140

Resolution 602-I-16, “Equality for Future Meetings Organized or Sponsored by the AMA,” introduced by the Young Physicians Section, asked that all future meetings and conferences organized and/or sponsored by our American Medical Association (AMA), not yet contracted, only be held in towns, cities, counties and states that do not have discriminatory policies based on race, color, religion, ethnic origin, national origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age.

The reference committee recommended referral of the resolution based on a variety of divided testimony involving the complexity of staying abreast of developments across such a wide swath of governmental units and concerns that laws and ordinances may change, and thus communities may be overlooked or inappropriately considered based on outdated information, and also testimony that there may be other categories of non-discrimination not incorporated in the resolution. Testimony also noted that the policy should not restrict AMA business decisions in unproductive or costly ways and suggested establishing a process to vet these types of decisions.

Our AMA has strong policies against discrimination in all forms and our current policy on lodging and accommodations includes non-discrimination. Nevertheless, the Board is supportive of the spirit and intent of the resolution and believes modifying AMA Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” accordingly is desirable.

AMA management already has processes in place in its selection of sites and corresponding contract negotiations to minimize unproductive or overly costly meeting venues. The Board has requested AMA management to negotiate cancellation provisions into contracts for future meetings for this non-discrimination purpose whenever possible and fiscally reasonable.

In examining this issue the Board notes that current AMA Policy G-630.140, while addressing clubs, restaurants or other institutions, does not specifically address towns, cities, counties and states. The Board’s recommendation addresses that issue.

RECOMMENDATION

The Board of Trustees recommends that Policy G-630.140 be amended by addition to read as follows in lieu of Resolution 602-I-16, and that the remainder of this report be filed:

AMA policy on lodging and accommodations includes the following: (1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. (2) 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. (3) All meetings and conferences organized and/or

primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. (4) It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy. (5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

18. ELIMINATE THE REQUIREMENT OF H&P UPDATE (RESOLUTION 710-A-16)

Reference committee hearing: see report of [Reference Committee G](#).

HOUSE ACTION: REFERRED

INTRODUCTION

At the 2016 Annual Meeting of the House of Delegates (HOD), Resolution 710-A-16, “Eliminate the Requirement of H&P Update,” was referred. Resolution 710-A-16, sponsored by the Ohio Delegation, asks our American Medical Association (AMA) to work to change the Centers for Medicare & Medicaid Services’ (CMS) Medicare conditions of participation regulations governing the medical history and physician examination update and documentation requirements (H&P update) prior to surgery or a procedure as follows:

Change regulation 42 C.F.R. section 482.24 (c)(4)(i)(B) to read as follows:

When the medical history and physical examination are completed within thirty days before admission or registration, documentation of an updated examination of the patient must be placed in the patient’s medical record within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, only if any changes have occurred in the patient’s condition.

Change regulation 42 C.F.R. section 482.51(b)(1)(ii) to read as follows:

When the medical history and physical examination are completed within thirty days prior to admission or registration, an updated examination of the patient must be completed and documented within twenty-four hours of admission or registration only if any changes have occurred in the patient’s condition.

The HOD supported referral of Resolution 710-A-16 because testimony was mixed and the topic involved clinical, legal, and regulatory considerations. The sponsoring delegation testified that physicians should not have to document “no change” in the patient’s H&P update on the day of a procedure or surgery. Other testimony emphasized the importance of documenting updates on the date of surgery and potential risks associated with not documenting changes or “no change” in the patient’s condition. One speaker noted that H&P update requirements are not particularly burdensome to physicians. Additional speakers noted the complexity of the issues brought up by Resolution 710-A-16, and that patient needs may differ depending on their health and the procedures they are receiving.

AMA POLICY

The AMA does not have policy that is directly applicable to whether the documentation requirements of the H&P update are appropriate. There is, however, policy that is germane to the issue of medical record authentication in the context of physical examinations, though it provides for a streamlined approach—namely a single signature to authenticate a host of services and procedures provided to a patient. Policy H-225.965, “Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record,” provides:

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.

DISCUSSION

In order to participate in the Medicare program, health care providers, such as hospitals, must comply with statutory and regulatory Conditions of Participation (COPs) requirements. The COPs are established through notice and comment rulemaking and represent Medicare's minimum health and safety standards. CMS ensures compliance by conducting (or contracting with state health survey agencies to conduct) scheduled or unscheduled investigations (called surveys) to assess compliance. These surveys will include sampling and review of patients records, standard operating procedures, and associated documentation among other survey activities. Alternatively, hospitals may also receive certification to participate in the Medicare program by obtaining accreditation from an accrediting body approved by CMS. Accredited institutions are deemed to meet all of the Medicare COPs, with some exceptions. Currently, CMS-approved accrediting bodies for hospitals include, but are not limited to, The Joint Commission and the American Osteopathic Association.

In 2006, CMS issued as a final rule: *The Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations*. The final rule incorporated requested changes that reduced compliance burdens on patients and physicians. Among other things, the final rule expanded the timeframe for completion of the pre-operative H&P to 30 days and expanded the number of permissible professional categories of individuals who may perform the history and physical examination. The final rule also required that all orders, including verbal orders, be dated, timed, and authenticated by a practitioner responsible for the care of the patient. The proposed rule would have required the pre-operative H&P to be completed only by a physician credentialed by the medical staff at the admitting hospital. This would have excluded for many patients their primary care provider who may not necessarily be credentialed and privileged at the admitting hospital. CMS struck this requirement and put an alternative requirement in place as outlined below:

If a patient's H&P is completed before admission to the hospital, an updated examination must be completed and documented in the patient's medical record within 24 hours after admission, but before a surgical procedure. This update to the H&P would be completed after the patient is admitted to the hospital by a physician, oromaxillofacial surgeon or other qualified individual who has been granted these privileges by the medical staff in accordance with State law. Therefore, if the H&P was completed by the patient's primary care provider, the H&P would be reviewed, the patient would be examined, and the H&P would be updated by an individual who has been credentialed and privileged by the medical staff to conduct an H&P. If upon review, the H&P done before admission is found to be incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document a new H&P within 24 hours after admission, but before a surgical procedure. The practitioner completing the update is responsible for ensuring that the H&P documented in the medical record is complete and accurate.

While this documentation requirement was established as an alternative to a more onerous proposed Medicare requirement that would have hindered patient access to care, it is possible to forgo this requirement while still ensuring an updated H&P exam is conducted by qualified individuals with privileges. Specifically, an alternative requirement could still mandate such a review is conducted, but establish a legally enforceable conclusion that the H&P remained unchanged when no documentation is submitted to the contrary. Furthermore, the new Trump Administration has expressed strong support for reducing regulatory burdens and the AMA is engaged in efforts to identify a wide range of administrative burdens that do not enhance patient care and that re-direct physician time away from patient clinical care.

CONCLUSION

The H&P update requirement constitutes a compliance burden for physicians when a patient's health status remains unchanged without a direct clinical benefit. It is reasonable to create a regulatory presumption that the H&P update was performed and remained unchanged if documentation to the contrary is not provided. Qualified individuals with

privileges would still have to document when changes have occurred; thereby, safeguarding patient safety and ensuring a basic standard of care is met.

RECOMMENDATION

The Board of Trustee recommends that Resolution 710-A-16 be adopted and the remainder of the report be filed.

19. CEJA AND HOUSE OF DELEGATES COLLABORATION

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policy G-600.009

Policy [D-600.957](#), “CEJA and House of Delegates Deliberation,” adopted in June 2016, asks the American Medical Association (AMA) to evaluate:

1. how the collaborative process between the House of Delegates (HOD) and the Council on Ethical and Judicial Affairs (CEJA) can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy; and
2. how a periodic review of *Code of Medical Ethics* guidelines and reports can best be implemented.

Report 3-I-16, “CEJA and House of Delegates Collaboration,” by the Council on Ethical and Judicial Affairs (CEJA) reviewed Bylaws that set out CEJA’s responsibilities, presentation of its reports and recommendations to the HOD, and actions available to the HOD with respect to CEJA reports and recommendations [1]. Report 3 also described CEJA’s historical practice with respect to soliciting input on matters it was considering and proposed an additional mechanism by which to receive comment on work in progress. However, testimony was offered to the effect that Report 3 did not adequately address important underlying issues of the relationship between the Council and the HOD.

In light of the importance of the *Code of Medical Ethics* and the potential implications of the concerns expressed in testimony for Bylaws relating to the Council on Ethical and Judicial Affairs, the matter was referred to the Board of Trustees (BOT) for further consideration. Your Board of Trustees believes that the question of review of the *Code* (D-600.957(2)) is adequately addressed in current AMA policy for the reasons noted below. This report therefore focuses on the issue of collaboration between the Council and the House (D-600.957(1)).

THE CODE OF MEDICAL ETHICS

The *Code of Medical Ethics* is one of the founding pillars of our American Medical Association and the pre-eminent contemporary statement of the values and commitments of the medical profession overall. In an article celebrating the 150th anniversary of the AMA *Code* the late physician-philosopher Edmund Pellegrino noted that a code of ethics is “in effect, a collective promise of fidelity”[2]. It is a vehicle that transmits the profession’s “tradition of dedicated service” and translates ethical knowledge and commitment into practice. A code of ethics embodies the “moral truth” of medicine as a special kind of human activity and “defines the integrity of medicine as a moral entity with its foundations in something more than mere social convention.”

A code of ethics thus is the foundation for patient and public trust in medicine as a profession and undergirds the social contract on which the profession’s freedom to regulate itself depends. Moreover, by clearly articulating physicians’ primary ethical and professional commitment to patients, a code of ethics sustains physicians’ role as advocates for patients in the face of ongoing change in health care.

PERIODIC REVIEW OF THE *CODE*

The ethics guidance set out in the Principles of Medical Ethics and the Opinions of the Council on Ethical and Judicial Affairs that make up our *AMA Code of Medical Ethics* reflect enduring principles of professional ethics. Thus a thorough review of the *Code*, such as that just completed through an eight-year process, should necessarily be rare. The House of Delegates already has available to it a mechanism by which it can request that a specific Opinion be reconsidered, i.e., by adopting a resolution so requesting. The Board believes this mechanism could equally be employed to request review of a broad topic area, e.g., genetic medicine, when advances in medical science, technology, or practice or evolution of public policy give rise to new ethical challenges or require clarification of how existing ethics guidance should be interpreted and applied. For these reasons, your Board of Trustees concludes that D-600.957(2) is adequately addressed in existing AMA policy and practice.

CEJA-HOD COLLABORATION

Questions about the relationship between the House of Delegates and the Council on Ethical and Judicial Affairs have arisen from time to time over the years. Such questions were addressed at length in a joint report by CEJA and the Council on Constitution and Bylaws presented to the HOD in December 1991 [3]. As that report observed:

Any proposals to clarify the procedures for Council opinions and reports must reflect two fundamental principles of the Constitution and Bylaws. First, the Council should be given a substantial degree of independence from the political process of the House as long as it is genuinely interpreting the Principles of Medical Ethics. Second, the House should be given mechanisms with which to check and balance the independence of the Council.

The report argued that the independence of the Council on Ethical and Judicial Affairs helps ensure that stakeholders view the AMA's ethics guidance as grounded in enduring principles "rather than the political temperament of the times," and expressed concern that perception otherwise would "undermine the legitimacy of the Council" and the stature of the *Code* as an "authoritative code for the entire profession."

The report further noted that the House has several mechanisms for oversight of CEJA activities. The House can influence the Council's deliberations through its authority to confirm appointment of members. Historically, the process of confirming appointment of a new CEJA member has occurred immediately following announcement of the candidate by the AMA President Elect during the opening session of each Annual Meeting of the House. In 2016, the nominee's conflict of interest disclosure was posted on the Annual Meeting website before the House opened. The posting was announced in the Speakers' Letter and by email to the House.

The House can also amend the Principles of Medical Ethics if it finds the Council's interpretations problematic. Finally, the House can pass a resolution requesting that the Council reconsider an opinion with which it disagrees.

The recommendations of this report were adopted as presented and are reflected in current Bylaws relating to the Council on Ethical and Judicial Affairs discussed below.

Current CEJA Practice

CEJA Repot 3-I-16 identified several channels through which the Council currently receives input at Annual and Interim meetings about reports in development: Open Forum sessions, testimony in the Reference Committee on Amendments to Constitution and Bylaws, and in response to stakeholder concerns about opportunity to comment on the draft modernized *Code of Medical Ethics*, and special "open house" conversations. The Council proposed to hold open house sessions again at the 2017 Annual and Interim meetings and to collect attendees' feedback on the value of such sessions.

CEJA also invites written review or presents work in progress in small face-to-face meetings with key stakeholders on a report-by-report basis and posts work in progress to its online forum (www.ama-assn.org/go/cejaforum) for comment by all AMA members and other individuals who have created an AMA account. In addition, the Council receives input between meetings of the House from individuals and delegations who communicate with staff directly.

Having time during Annual and Interim meetings dedicated to giving feedback on CEJA reports and recommendations through the reference committee process offers an efficient way for delegations and individuals to provide input, and CEJA reports benefit significantly from the focused collective attention that reference committee promotes. CEJA reports are only rarely adopted on first presentation to the House and the usually iterative process helps ensure that multiple values are heard and balanced as compellingly as possible in keeping with the Council's mandate.

RELEVANT AMA POLICY

As CEJA 3-I-16 observed, AMA policy is largely silent with respect to the means by which CEJA should collaborate with the House of Delegates. The [Bylaws](#) grant CEJA authority to interpret the Principles of Medical Ethics (6.5.2.1) and to investigate and make recommendations to the House regarding "general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public" (6.5.2.3). Bylaw 2.13.1.1 provides that all matters pertaining to the Principles of Medical Ethics be referred to the Reference Committee on Amendments to Constitution and Bylaws. Bylaw 2.13.1.7.2 provides that CEJA Opinions be treated as informational and filed and that motions may be made to extract an opinion and a request made to CEJA to withdraw or reconsider it. Bylaw 2.13.1.7.2 also provides that the House may adopt, refer, or not adopt CEJA reports, but that they may be amended for clarification only with the concurrence of the Council.

Policy [G-615.040](#), "Opinions and Reports of CEJA," provides that CEJA will present its opinions as informational and may provide to the House an analysis of issues and explanation for its opinion at the Council's discretion. G-615.040 also replicates provisions of Bylaw 2.13.1.7.2 regarding treatment of CEJA opinions, as well as provisions regarding the treatment of CEJA reports.

OPPORTUNITIES TO ENHANCE COLLABORATION

The Board of Trustees concurs that, as the 1991 CEJA-CCB joint report argued, balancing independence and oversight are key for productive, collegial collaboration between the Council on Ethical and Judicial Affairs and the House of Delegates. The integrity and stature of the *Code of Medical Ethics* as guidance for all physicians require that CEJA be able to carry out its deliberations independent of the political process of the House of Delegates. That includes not only identifying areas in which ethics guidance is called for, but also being able to define the scope of ethics guidance so as to address key underlying ethical issues rather than direct its reports and recommendations to specific incidents or "trouble cases" even when a resolution may expressly seek clarification about ethically appropriate conduct only in very particular circumstances.

At the same time, it is essential that the Council conduct its work as transparently as possible, identifying appropriate opportunities for input, discussion, and debate as it develops ethics guidance for the AMA. CEJA has proposed to schedule regular "open house" conversations at Annual and Interim meetings going forward and to solicit feedback on the utility of such sessions. The Board believes this proposal has potential to improve collaboration between the HOD and the Council.

CEJA's internal work process may also lend itself to creating additional opportunities for the Council to receive feedback. CEJA reports are developed through an iterative, multi-stage process that begins with a review of key literature to identify salient issues and continues through development of the Council's foundational ethics analysis in discussion over multiple meetings, and finally drafting of recommendations based on the ethics analysis. CEJA could post work product at one or more of these various stages to offer AMA members and other AMA account holders additional opportunity to share feedback with the Council.

The Board recognizes, however, that the greatest opportunity for significant collaboration between CEJA and the House takes place at the Annual and Interim meetings. CEJA's project to modernize the *Code of Medical Ethics* may be instructive in addressing this issue. In response to concerns that the draft *Code* was too complex to be included as one item of business among many others on the docket of the Reference Committee on Amendments to Constitution and Bylaws, at the 2015 Interim and 2016 Annual meetings the Speakers convened a special reference committee dedicated solely to hearing testimony on the draft modernized *Code*. While the Board appreciates that dedicating a reference committee to CEJA business poses considerable logistic challenge; it is conceivable that the volume, complexity or nature of CEJA reports and opinions may again rise to the level to justify a separate reference committee.

CONCLUSION

The *AMA Code of Medical Ethics* was the first national professional code of ethics in the world and remains the authoritative statement of medicine's ethical commitments. Ensuring that the *Code* continues to provide timely guidance is one of the core responsibilities of our AMA.

The AMA House of Delegates brings a wide range of professional expertise and experience as well as diverse personal and professional views to matters of ethics in the practice of medicine. The House thus offers an invaluable proving ground for ethics guidance that transcends specialties and practice settings to speak to the profession as a whole.

At the same time, the House offers a unique opportunity and a distinctive challenge for the Council on Ethical and Judicial Affairs tasked to create that policy: to respect this diversity while ensuring that guidance remains strongly grounded in the "moral truth" of medicine tempered by the insights from contemporary bioethics, independent of political processes.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That the Council on Ethical and Judicial Affairs be encouraged to carry forward its proposals for enhancing transparency and opportunity for input.
2. That, consistent with Bylaw 2.13.1.1, the Speakers consider convening additional sessions of the Reference Committee on Amendments to Constitution and Bylaws when appropriate and feasible to accommodate CEJA business.
3. That the President-Elect and the Speakers are encouraged to consider formalizing a process of announcing a candidate for CEJA membership before the House is asked to confirm the candidate.

REFERENCES

1. American Medical Association. Council on Ethical and Judicial Affairs Report 3-I-16: CEJA and House of Delegates Collaboration. November 2016.
2. Pellegrino, ED. One hundred and fifty years later: the moral status and relevance of the *AMA Code of Medical Ethics*. In Baker RB, Caplan AL, Emanuel LL, Latham SR, eds. *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society*. Baltimore: The Johns Hopkins University Press; 1999:107–123.
3. American Medical Association. Joint Report of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws: Clarification of House Procedures with Respect to the Opinions and Reports of the Council on Ethical and Judicial Affairs. December 1991.

20. STUDY OF MINIMUM COMPETENCIES AND SCOPE OF MEDICAL SCRIBE UTILIZATION

Reference committee hearing: see report of [Reference Committee G](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policies H-35.966, D-478.967 and D-478.976

INTRODUCTION

At the 2016 Interim Meeting, Policy D-478.976, "Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians," was amended by the House of Delegates. This report serves as a summary of the medical scribe industry, training requirements, scope of work, utilization in various specialties, and potential benefits and drawbacks of medical scribe utilization in health care.

BACKGROUND

It is widely accepted practice for healthcare professionals in advanced team-based models of care, such as medical assistants, nurses, nurse practitioners or physicians assistants, to assist with visit note documentation while performing clinical tasks commensurate with their level of training. It is also recognized that medical students and residents may document as part of their training. It is important to distinguish these individuals from unlicensed clerical scribes whose only responsibility is documentation. For the purposes of this report, the term “medical scribe” refers only to the unlicensed individuals hired in a medical practice to enter information into electronic health records (EHR) or chart at the direction of a physician or practitioner.¹ Medical scribes work in a variety of practice settings, including hospitals, emergency departments, physician practices, long-term care facilities, ambulatory care centers and others. Medical scribes always work with a practitioner and are not permitted to make independent decisions about patient care or translations during data entry.²

With new regulatory requirements comes a growing dependence on EHRs throughout the health care industry. The time expenditure required to maintain compliant records has resulted in increased utilization of medical scribes to assist with this work. Poor usability of EHR systems has led to increases in the amount of time spent completing entries in an EHR, and has significantly affected the amount of clinical face time physicians spend with patients. For every hour of clinical face time with patients, physicians spend nearly an additional two hours doing EHR and desk work.³ It has been found that access to documentation support, such as that of a medical scribe, can increase the amount of direct face time with patients during a visit.³ It was estimated in 2014 that 10,000 medical scribes were employed.⁴ The American College of Medical Scribe Specialists (ACMSS) estimated there were 20,000 medical scribes in employment in 2016 and projects this will reach 100,000 in 2020.⁵ The nation’s largest professional scribe training and management company organization currently (2017) employs over 13,000 medical scribes.

AMA POLICY

Our AMA recognizes the importance of EHR technology and through its policy commits to advocating for research and physician education on EHR adoption, and to design best practices concerning key features to improve the quality, safety, and efficiency of health care (Policy D-478.976, “Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians”). The AMA also acknowledges the important role allied health professionals, such as medical scribes, have in the practice of medicine in today’s health care environment. The AMA endorses a principle on health manpower that recognizes the legal and ethical responsibilities both physicians and allied health professionals have for patient care (Policy H-200.994, “Health Workforce”). It is AMA policy that the services of new health professionals may be made available for patient care within the scope of their authorized practice, and that medical staff bylaws should establish procedures to determine and specify the functions of and services provided by such professionals (Policy H-35.996, “Status and Utilization of New or Expanding Health Professionals in Hospitals”). It is also AMA policy to continue working with state and specialty medical societies to collect, analyze, and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access, quality, and cost (Policy H-35.966, “Protecting Physician Led Health Care”).

MEDICAL SCRIBE TRAINING AND CERTIFICATION REQUIREMENTS

The minimum requirements to enter into a medical scribe training program, whether it is onsite at a hospital or in a private organization, are a high school diploma and basic computer skills. The coursework in a typical training program covers the following minimum competencies:

1. Medical terminology
2. Medical note structure
3. EHR navigation
4. History of present illness

Licensure or certification is not required for medical scribes to find employment, however several organizations have developed certification programs for individuals interested in obtaining the credential. The Medical Scribe Certification & Aptitude Test (MSCAT) is the most widely used certification and is offered by ACMSS.⁶ Full recognition of this certification is awarded only after 200 hours of employment experience are completed. Many practices employ medical scribes who are students either preparing for or in medical or nursing school. This can be a

great fit for both physician and student, but is not necessarily a long-term solution for an employer since most students will move on after one or a few years. Physicians and practices seeking long-term investment in a medical scribe staff may choose to employ those not seeking a medical or nursing degree.

MEDICAL SCRIBE SCOPE OF WORK

Physician organizations that use or plan to use medical scribes must clearly define responsibilities for the role and document set policies and procedures which can help optimize the use of the medical scribe and minimize risks and challenges.² The predominant responsibilities of medical scribes include performing documentation in the EHR, gathering information for the patient's visit, and assisting with the physician's delivery of efficient patient care.⁷ The Joint Commission states the scope of work and responsibilities of a medical scribe can be to¹:

- Document the previously determined physician's or practitioner's dictation and/or activities.
- Assist practitioners in navigating the EHR and in locating information such as test results and lab results.
- Support work flow and documentation for medical record coding.
- Accompany the physician or practitioner and record information into the medical record.

One set of established standards, from ScribeMD, states that medical scribes do not act independently of a physician or licensed practitioner, or participate in other tasks associated with patient care such as transporting specimens, answering phones, or assisting patients.

MEDICAL SCRIBE UTILIZATION IN VARIOUS HEALTH CARE SETTINGS

Medical scribe services can be implemented in many practice settings, from solo or small practices to large hospitals or health systems. Medical scribes may be directly employed by the practice or hospital, or contracted through a third party. Use of a medical scribe can be beneficial to a solo or medium-sized practice by helping to bridge volume gaps resulting from increased patient loads and enabling the physicians to focus more on the patient during a visit.⁸ In a large hospital system, medical scribes can potentially improve efficiency in workflow and increase revenue, and larger systems are more likely to have the resources available to invest in medical scribe services.⁹

A systematic review of studies identified some of the different ways in which medical scribes can operate within a medical practice depending on a variety of factors. "In some settings medical scribe services may be contractually arranged with an independently operated scribe company, whereas in other settings scribes may be direct employees of the health system or clinic. Likewise, the tasks performed by the scribe can vary from setting to setting. In settings with fully functional EHRs the scribe might actively participate in the clinical encounter, serving as an interface between the EHR and the clinician; for example, the scribe could communicate to the clinician information generated by the EHR such as automatic warnings, prompts, or reminders. In other settings, the scribe's role could be essentially invisible, where direct interactions with the clinician or patient are kept to a minimum."¹⁰

MEDICAL SCRIBE UTILIZATION IN VARIOUS SPECIALTIES

Research on the scope or specific effects of medical scribe use within a variety of specialties is limited. One such review identified five studies, including three that measured medical scribe use in emergency departments, one in a cardiology practice and one in a urology clinic.¹⁰ It was concluded that although the limited evidence suggests the use of medical scribes may improve clinician satisfaction, productivity, time-related efficiencies, revenue, and patient-clinician interactions, more robust study on the subject is needed.

A member survey conducted by the American Society of Cataract and Refractive Surgery demonstrated that 88.4 percent of ophthalmologists have an EHR and of those, 86.6 percent utilized medical scribes in practice.¹¹ The practices with 5 to 15 physicians on staff were most likely to use scribes, and solo practices were least likely. On average, practices employed 9 medical scribes, and over 84 percent of respondents indicated they were satisfied with their use of medical scribes. Some ophthalmologists remarked that while they are satisfied with their medical scribes, they would prefer not to have to use them, and many indicated they have their technicians scribe during patient visits.

A majority of hematologists polled by the American Society of Hematology reported they do not use medical scribes.¹² Reasons for low utilization among this specialty included cost, doctor or patient discomfort, lack of necessity for younger physicians more agile in the EHR, or employment of voice to text technology. Twenty percent

of dermatologists reported in the 2014 Practice Profile Survey that the use of medical scribes increased after the implementation of an EHR in their practice.¹³

Physiatrists and psychiatrists are among specialists who report rare use of medical scribes.^{14, 15} Another small study of 40 Federally Qualified Health Centers—practices that typically provide primary care in medically underserved urban and rural communities—indicated that only 7.5 percent of those centers reported using a medical scribe.⁹

More research is available on the broader topic of team documentation, but it primarily includes measures of documentation completed by other members of the health care team such as physician assistants, nurse practitioners and medical assistants, all of whom perform tasks outside the scope of work of a medical scribe. This may be a beneficial view of how other health professionals on the whole have an effect on patient care and other aspects of medical practice, but it does not provide a focused observation of medical scribe utilization.

REPORTED BENEFITS OF MEDICAL SCRIBE USE

In a 2015 retrospective comparative study, physicians with medical scribes saw 9.6 percent more patients per hour than physicians without a medical scribe. The increased productivity resulted in over 3,000 additional relative value units (RVUs) and more than \$1.2 million in revenue.¹⁶ Another study demonstrated a nearly 60 percent increase in physician productivity (patients per hour) with the use of a medical scribe. With the use of medical scribes, patient visits were on time as scheduled, documentation was mostly or completely finished within the clinic time frame, and physicians were not working after clinic hours to complete documentation.¹⁷

Physicians who use medical scribes say they “feel liberated from the constant note-taking that modern [EHRs] demand” and they can “think medically instead of clerically.”¹⁸ When face-to-face time with the patient increases, physicians are able to listen and respond more thoroughly without the distraction of entering data into the EHR, giving patients a better experience. Physicians are in turn able to provide the level of care they find the most satisfying.³

Improved case mix index and increased revenue have been reported after the introduction of medical scribes into a health care setting. Additionally, inpatient physicians also experience a reduction in the amount of time required to update patient charts (10 minutes on average).¹⁹

POTENTIAL DRAWBACKS OF MEDICAL SCRIBE USE

Medical scribes are not required to complete rigorous or comprehensive training, and although some medical scribes are pre-med students or students seeking other healthcare related careers, most are only high school educated. There is no required certification for medical scribes, and the profession is largely unregulated by state or federal governments.

The scope of work for medical scribes is intentionally limited. The Health Information Technology for Economic and Clinical Health (HITECH) Act, as well as The Joint Commission standards, restrict the types of tasks medical scribes are permitted to perform, prohibiting them from assisting with or performing x-rays, tests or order entry for prescriptions. When compared with other health care team members who are permitted to assist with more tasks, a medical scribe may fall short of a medical practice’s needs.

Health information management experts list other workflow challenges that may arise with the use of medical scribes²:

- Medical scribes in the exam room may cause patients to be less honest or withhold important personal information necessary for treatment.
- Use of a medical scribe will change existing documentation processes and workflows for multiple members of the health care team, necessitating a full-scale review and possible revision of processes.
- Provider verification and authentication of scribed documentation for accuracy may slow down overall workflow.
- An inexperienced medical scribe who does not have medical terminology and clinical workflow knowledge may cause documentation errors leading to liability and other risks.
- Utilizing a medical scribe does not completely eliminate the risk of error or documentation mistakes.

One expert opines that the use of medical scribes may stifle improvements to EHR technology. By providing a workaround to EHRs, thus decreasing reported physician dissatisfaction with EHR technology, pressure on the industry to continue developing improvements may recede, slowing or preventing necessary improvements.²⁰

DISCUSSION

The widespread use of medical scribes could impact healthcare delivery on several levels including patient care, patient and physician satisfaction, organizational structure and operations, costs and expenditures (both in private and public sectors), and others. While there are some drawbacks to utilization of medical scribes, according to some experts, they may be favorably outweighed by its benefits.

Given the evidence that physicians are increasingly dissatisfied in practice,²¹ burnout is on the rise,²² health care costs continue to increase,²³ and patients are left to bear the brunt of the other things that demand their doctor's time,^{24, 25} it is clear that relief is needed. Based on the published evidence, team documentation, including the use of medical scribes, is useful for some physicians and medical practices to improve the environment of healthcare delivery as well as patient and physician satisfaction. It is apparent that as usability issues in EHRs persist the use of medical scribes will continue to grow, suggesting that sustained attention to medical scribe use may be of benefit. In addition, continued focus on improving the usability of EHRs will be important to assist physicians with documentation and over the long run may reduce the need for medical scribes.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That our American Medical Association reaffirm AMA Policy H-35.966, "Protecting Physician Led Health Care."
2. That our AMA monitor the medical scribe industry periodically to identify important trends.
3. That our AMA continue to review and promote strategies that help improve physician practice workflow.
4. As this report has provided the requested study, that Policy D-478.976, "Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians" be amended by rescission of the fourth paragraph to read as follows:
 - 1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and support more informed decision making in the selection of EHRs.
 - 2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.
 - 3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.
 - 4) ~~Our AMA will study medical scribe utilization in various health care settings.~~
 - 5) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

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21. RISK ADJUSTMENT REFINEMENT IN ACCOUNTABLE CARE ORGANIZATION (ACO) SETTINGS AND MEDICARE SHARED SAVINGS PROGRAMS (MSSP)

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2016 Annual Meeting, the House of Delegates (HOD) adopted Policy D-160.927, "Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs," with a progress report back at the 2017 Annual Meeting. This policy asks that:

Our AMA will continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries and report progress back to this House at the 2017 Annual Meeting.

This report provides background on risk adjustment in MSSP ACOs and provides an update on the AMA's activities on this issue.

BACKGROUND

Risk Adjustment

Risk adjustment is a method used by the Centers for Medicare & Medicaid Services (CMS) to adjust payments to health plans based on the health status and demographic characteristics of their patient populations. The idea is to use historical spending variations for different conditions and demographic factors to predict future spending variations, and then adjust capitation payments for these variations in order to improve their accuracy. One way CMS applies risk adjustment is through the hierarchical condition categories (HCC) model. This model was originally implemented in 2004 to adjust Medicare capitation payments to Medicare Advantage (MA) health care plans for the health expenditures of their enrollees. It was designed to pay plans appropriately for their expected relative costs. Ideally, CMS uses HCC risk scores to pay MA plans that disproportionately enroll healthy beneficiaries less than it pays plans that enrolled beneficiaries with a higher average risk profile.¹

The HCC risk adjustment model works by mapping ICD-10 codes to Condition Codes. These Condition Codes are then placed into hierarchies reflecting severity and cost, which become the HCCs. Risk adjustments are calculated and data are submitted by MA plans to CMS three times each year, including an initial risk score, a mid-year update, and a final reconciliation. The risk adjustment data sources include hospital inpatient and outpatient facilities and physician records. Initially HCCs were only applied to MA plans; however, CMS also now uses the HCC risk adjustment model to set and update ACO benchmark expenditure amounts.

Benchmarks are target levels of Medicare spending for the patient population assigned to an ACO. If total Medicare expenditures for the ACO's patients end up being more than the benchmark, the ACO is viewed as experiencing financial losses to Medicare, and some ACOs are required to repay CMS a share of these losses. If total expenditures are less than the benchmark, CMS pays the ACOs a share of the savings.

“Newly” Versus “Continuously” Assigned Beneficiaries

CMS assigns Medicare patients to ACOs each year based on an analysis of submitted claims for primary care services. Patients who receive a plurality of their primary care services for a year from physicians participating in an ACO are assigned to that ACO for the year. Because patients do not “enroll” in ACOs the way that they enroll in MA plans, there is a significant turnover in each ACO's assigned patient population from year to year. Patients who continue to be assigned to the same ACO over time are called “continuously” assigned, and the other patients are called “newly” assigned.

For the continuously assigned population, the policy set by CMS caps their HCC scores at the ACO's baseline risk. CMS only allows *an increase* in the risk adjustment from the baseline based on demographic changes, such as a higher percentage of the ACO's population being enrolled in both Medicare and Medicaid programs, but does not allow increases due to changes in the severity or case mix of the patient population's conditions. CMS does *reduce* risk adjustments from the baseline, however, if the continuously assigned patients' severity or case mix is reduced. For the newly assigned population, CMS allows annual adjustments based on changes in severity and case mix each year.

By only counting HCC scores that work against the ACO for the continuously enrolled population, the current policy disadvantages ACOs that succeed in improving their patients' health status. In addition, the refusal to increase risk scores to account for increased acuity in patients can lead to benchmarks being set too low and make it more difficult for ACOs to earn shared savings.

This policy may stem from a CMS concern that ACO participants would augment their ACO's risk scores through changes in coding and documentation regardless of their patients' actual severity and case mix, gaining unearned shared savings. As ACO participants are paid based on fee-for-service claims submitted directly to Medicare, however, not on a capitated basis, they do not have access to the same tools as MA plans for improving documentation of patient risk. For example, whereas fee-for-service diagnoses are drawn only from health care claims submitted for payment, MA plans may also review medical records and report all diagnoses that are supported in the record.

AMA ADVOCACY

AMA Policy H-160.915, “Accountable Care Organization Principles,” states, “the ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, ethnicity, and health status.” In addition, policy H-390.849, Physician Payment Reform, states that “AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality, and risk adjustment.” Consistent with these policies, AMA advocacy efforts have continually sought refinements in risk adjustment, including the specific risk adjustment revision called for in Policy D-160.927.

Letters to the Administration

On February 27, 2015, the AMA’s collaborative comments to CMS on the MSSP proposed rule addressed the issue of risk adjustment methodology in ACOs. Specifically, the comments noted that, “While we believe CMS should incorporate the full growth in HCC risk scores across all content years, at a minimum, we urge CMS to recognize the full growth for beneficiaries in their first year of assignment to the ACO.” The letter also urged CMS to continue researching alternative risk adjustment models.

Furthermore, the AMA’s comment letter to CMS on March 25, 2016, on the proposed rule *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations* also addressed the issue of risk adjustment for newly and continuously assigned beneficiaries. The letter contained a section on risk adjustment and coding intensity adjustment which noted that the AMA continues to oppose CMS’ use of different methods for newly and continuously assigned beneficiaries. Specifically, the letter opposes CMS’ policy to take into account increases in severity and case mix only for newly-assigned beneficiaries while restricting risk score increases for continuously assigned patients to demographic factors only. The letter stated that it is unreasonable to assume a provider organization, however effective, can manage a population such that patient conditions never worsen over time and patients never carry a higher disease burden. The letter urged CMS to, within limits, allow risk scores to increase year-over-year within an agreement period for continuously assigned beneficiaries.

The AMA reiterated this point in a December 15, 2016, joint comment letter on the Medicare Access and CHIP Reauthorization Act final rule, which addressed CMS’ plans for a new ACO Track 1+ model.

CONCLUSION

The AMGA, the sponsor of the resolution underlying Policy D-160.927, was a signatory to these three joint comment letters seeking a more balanced approach to ACO risk adjustment. As of the date this report was drafted, CMS has not changed its policy.

The AMA will continue to urge CMS to improve risk adjustment methodology in ACOs by allowing HCC risk scores to increase annually for both newly and continuously assigned Medicare beneficiaries, and will look for opportunities to seek a change in this policy with the new Administration.

REFERENCE

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APPENDIX - Current AMA Policy

H-160.915, “Accountable Care Organization Principles”

Our AMA adopts the following Accountable Care Organization (ACO) principles: 1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician’s primary ethical and professional obligation is the well-being and safety of the patient.

2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician’s medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients’ interests first.

A. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.

B. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.

C. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.

D. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

A. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

B. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

C. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.

D. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

E. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.

8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution

methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.

10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.

12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.

13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

H-390.849, "Physician Payment Reform"

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

- a) promote improved patient access to high-quality, cost-effective care;
- b) be designed with input from the physician community;
- c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
- d) not require budget neutrality within Medicare Part B;
- e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
- f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
- g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
- h) use adequate risk adjustment methodologies;
- i) incorporate incentives large enough to merit additional investments by physicians;
- j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
- k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
- l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
- m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

22. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2007 HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, "AMA Policy Database"). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the

sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA councils as a guide, the staffs of the AMA councils determine which policies should be reviewed by which councils.
- For the Annual Meeting of the House, each council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents recommendations from the Council on Legislation on the disposition of the House policies that were assigned to it. The Council's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

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

APPENDIX - Recommended Actions on 2007 House Policies

Policy Number	Title	Text	Recommendation
H-60.948	Child Protection Legislation	The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes. Citation: (Sub. Res. 219, I-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.
H-60.949	Opposition to Parental Rights Amendments	The AMA opposes state or federal legislative proposals (sometimes but not always known as “Parental Rights Amendments”) that might give parents the right under law to harm a child or adolescent, and educate its members and the public regarding the potentially dangerous effects such initiatives represent to the public health and particularly to the health of our children. Citation: (BOT Rep. 24, A-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.
H-60.962	Enforcement of Child Labor Laws	The AMA will work in conjunction with all appropriate organizations and specialty societies to enhance physician awareness of the problems and dangers associated with the illegal employment of children. Citation: (Sub. Res. 222, I-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-120.944	Standards, Laws, and Regulations Addressing Pain Medications and Medical Practice	<p>1. AMA policy is that states should examine their pain policies and seek to improve them, based on the Federation of State Medical Boards Model Policy and/or criteria established by the Wisconsin Pain & Policies Study Group.</p> <p>2. AMA policy is that the impact of state-based prescription drug monitoring programs on medical care, including appropriate pain management, should be evaluated.</p> <p>3. Our AMA will urge the Drug Enforcement Administration to work with physician organizations and other relevant stakeholders to reconstruct a document similar to "Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel" to serve as a legitimate resource for physicians, regulators, and law enforcement personnel.</p> <p>Citation: (CSAPH Rep. 6, A-07)</p>	Retain in part – The first clause is covered by Policy H-120.960, "Protection for Physicians Who Prescribe Pain Medication," and the third clause is covered by D-120.985, "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone," which covers the focus on education resources. The second clause remains relevant.
H-125.982	Medicare Part D Modifications	<p>Our AMA will seek necessary federal legislative changes to:</p> <p>a. have all pharmacy benefit programs participating in Medicare Part D offer at least one program that eliminates the coverage gap; and</p> <p>b. require that all pharmacy benefit programs participating in Medicare Part D inform the enrollees of lower cost/generic alternatives for each prescribed medication.</p> <p>Citation: (Res. 130, A-07)</p>	Rescind.
H-125.993	Legislation Prohibiting Therapeutic Substitution	<p>It is the policy of the AMA to: (1) oppose the establishment of a system at the federal or state level premised on therapeutic interchangeability of prescription drugs and formularies, since it will inevitably interfere with the ability of the patient's physician to assure that the medication prescribed is dispensed to the patient; (2) encourage and assist all states in passing legislation prohibiting the practice of therapeutic substitution; and (3) provide education to physicians and the general public that therapeutic substitution is not equal to generic substitution and provide information about the potential dangers of therapeutic substitution.</p> <p>Citation: (Sub. Res. 161, A-90; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed: BOT Rep. 9, I-97; Reaffirmed: CSAPH Rep. 3, A-07)</p>	Retain – This policy remains relevant.
H-130.950	Emergency Medical Treatment and Active Labor Act (EMTALA)	<p>Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;</p> <p>(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;</p> <p>(3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and</p> <p>(4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.</p> <p>Citation: (Sub. Res. 214, A-97; Reaffirmation I-98; Reaffirmation A-99; Appended: Sub. Res. 235 and Reaffirmation A-00; Reaffirmation A-07)</p>	Retain – This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-130.967	Action Regarding Illegal Aliens	Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. Citation: (BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07)	Retain – This policy remains relevant.
H-135.944	Further Limit of Asbestos in the United States	Our AMA supports legislation further restricting the use of asbestos in the United States. Citation: Res. 215, A-07	Retain – This policy remains relevant.
H-140.945	Code Status Requirement for Nursing Home Residents	The AMA opposes any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. The AMA urges other medical agencies and associations to oppose any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. Citation: (Res. 236, I-97; Reaffirmed: CEJA Rep. 7, A-07)	Retain – This policy remains relevant.
H-145.991	Gun Control	The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country. Citation: (Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)	Retain – This policy remains relevant.
H-145.992	Waiting Period Before Gun Purchase	The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S. Citation: (Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)	Retain – This policy remains relevant.
H-145.993	Restriction of Assault Weapons	Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as “Saturday night specials,” and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon. Citation: (Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)	Retain – This policy remains relevant.
H-145.999	Gun Regulation	Our AMA supports stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm. Citation: (Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07)	Retain – This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-160.956	Federal Funding for Safety Net Care for Undocumented Aliens	Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. Citation: (Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17-I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07)	Retain – This policy remains relevant.
H-175.976	Physician Protections in Fraud Data Bank Program	Our AMA will take all necessary actions to oppose and rescind the Health Care Integrity and Protection Data Bank. If not possible to repeal the establishment of the data bank, the AMA should take steps to protect the legal due process rights of practitioners. Citation: (Sub. Res. 803, A-99; Reaffirmation I-07)	Rescind – The Health Care Integrity and Protection Data Bank is no longer operational and has been superseded by the National Practitioner Data Bank. (NPDB). AMA policies on the NPDB, including H-355.975 Opposition to the National Practitioner Data Bank, now address these concerns.
H-175.982	Due Process for Physicians	It is the policy of the AMA to review current legislation governing fraud and abuse investigations and propose additional legislation and/or regulations as necessary and be prepared to take legal action in order to assure physicians due process in the conduct of fraud and abuse investigations. Our AMA requests the United States Department of Justice to establish a specific procedure for audit of a physician's office records which includes, but is not limited to, the following: (1) Patient care in the physician's office must not be interrupted during the course of the audit; (2) Patient ingress and egress must not be hindered during the course of an audit; (3) Normal telephonic communication must not be interrupted during the course of an audit; and (4) Normal routine of physician's care of patients in hospital or at home must not be interrupted. AMA policy is to pursue legislative, regulatory or other avenues to eliminate fines for inadvertent Medicare billing errors. Citation: (Sub. Res. 229, I-97; Reaffirmation A-99; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: Res. 12, A-06; Reaffirmation I-07)	Retain – This policy remains relevant.
H-260.966	CLIA Physician Office Laboratory Inspections	The AMA will seek and support legislation which would amend Section 353 of the Public Health Service Act to exempt physicians' office laboratories, except for those which perform a pap smear (Papanicolaou's Smear) analysis, from the clinical laboratories requirements of that section; and if this is not possible, the AMA will seek legislation or modification in the Centers for Medicare & Medicaid Services regulations which would allow physicians' office laboratories which do not do cytology, which have no significant deficiencies on inspection thus triggering a "revisit," which have satisfactory proficiency testing performances, which have no complaints against the lab and which have not undergone any significant changes (i.e., new director), be allowed to perform a self-assessment study called the Alternative Quality Assessment Survey (AQAS) in lieu of the biannual on-site inspection. Citation: (Res. 212, A-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-270.984	Change in Bankruptcy Code	The AMA supports the passage of an amendment to Section 523(a)(8) of the Bankruptcy Code, which would substitute the word “organization” for the word “institution.” Citation: (Res. 45, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.
H-270.987	Tax Law Changes	The AMA supports: (1) correction of inequities in the Tax Reform Act of 1986, including (a) the excise penalty tax on excess retirement distribution; (b) the excise tax on excess retirement accumulation; (c) the requirement of 10-year plan participation; and (d) the requirement of plan participation by the specified percentage of all employees; and (2) re-establishment of IRA rules as under the previous law. Citation: (Sub. Res. 138, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.
H-275.927	Medicare/ Medicaid Exclusion: Amendment of Definition of Conviction in Health Insurance Portability and Accountability Act	1. It is AMA policy that a recovering physician who is convicted of a felony for an offense which relates to the “unlawful manufacture, distribution, prescription or dispensing of a controlled substance,” and in order to resolve criminal charges arising from personal substance abuse, has entered into a first offender, deferred adjudication or other such arrangement (42 USC § 1320a-7[i]), should not be excluded from the Medicare and Medicaid programs for a mandatory five years. 2. Our AMA seeks legislation either to (a) delete this first offender, deferred adjudication definition of “conviction” from the statute, or (b) seek to exempt recovering providers from its application. Citation: (BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: CMS Rep. 9, A-07)	Retain – This policy remains relevant.
H-275.940	Physician Impairment	The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician. Citation: (Res. 701, I-97; Reaffirmed: CME Rep. 2, A-07)	Retain – This policy remains relevant.
H-290.970	Federal Legislation on Access to Community-Based Services for People with Disabilities	Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual’s needs, and to provide equal access to community-based attendant services and supports. Citation: (Res. 917, I-07)	Retain – This policy remains relevant.
H-305.941	Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid	AMA policy is to pursue changes to federal legislation or regulation, and specifically to the Higher Education Act, to change the cost of attendance definition for medical education to include costs for food, shelter, clothing and health care for all dependents, and for dependent care. Citation: (Res. 205, I-97; Reaffirmed: CME Rep. 2, A-07)	Retain – This policy remains relevant.
H-315.975	Police, Payer, and Government Access to Patient Health Information	(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define “health care operations” narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be	Retain – This policy remains relevant.

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		<p>undertaken with de-identified information.</p> <p>(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.</p> <p>(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.</p> <p>(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.</p> <p>(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.</p> <p>Citation: (Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07)</p>	
H-330.929	Lessening the Impact of New Legislation on Physicians: An Anti-Hassle Proposal	AMA policy is to promote and further strengthen the Practicing Physician Advisory Council (PPAC) whose purpose is to identify proposed changes and to recommend needed clarification of regulations and legislation that impact physicians and medical practices. Citation: (Res. 206, I-97; Reaffirmed: BOT Rep. 33, A-07)	Retain
H-435.949	Liability Relief for Physicians Who Volunteer at Free Clinics	Our AMA urges states to adopt legislation that provides for liability relief for volunteer physicians who serve at free clinics, deliver pro bono care, or volunteer in times of disaster.	Retain – This policy remains relevant.
H-435.951	Health Court Principles	<p>AMA PRINCIPLES FOR HEALTH COURTS</p> <ul style="list-style-type: none"> - These principles are intended to serve as legislative guidelines for state medical associations and can be amended on an as needed basis. - Health courts should be structured to create a fair and expeditious system for the resolution of medical liability claims - with a goal of resolving all claims within one year from the filing date. - Health court judges should have specialized training in the delivery of medical care that qualifies them for 	Retain – This policy remains relevant.

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		<p>serving on a health court.</p> <ul style="list-style-type: none"> - Negligence should be the minimum threshold for compensation to award damages. - Health court judgments should not limit the recovery of economic damages, but non-economic damages should be based on a schedule. - Qualified experts should be utilized to assist a health court in reaching a judgment. - Health court pilot projects should have a sunset mechanism in place to ensure that participating physicians, hospitals, and insurers do not experience a drastic financial impact based on the new judicial format. <p>I. Health Court Structure</p> <p>Jurisdiction</p> <ul style="list-style-type: none"> - Health courts should only be established at the state or local level. - If a health court is established on a statewide or local basis, then it should be established within the state’s trial court of general jurisdiction. Using the already established system would lessen the financial and administrative burden. - To capture all medical liability cases, a health court that is established as a statewide or local program should have exclusive jurisdiction over any lawsuit (contract or tort) which involves an injury arising from the alleged negligence of a health care provider. - Appeals should be handled within the health court system as well. - The jurisdiction’s discovery rules should be modified to be consistent with the timeline for resolving a case before a health court. - Eventually, health courts should have expanded jurisdiction over the validity of advance directives, managed care independent review decisions, and other health law issues. <p>Trial Format</p> <ul style="list-style-type: none"> - One option for a health court is to have a bench trial before a specially trained judge. - Another option is for a health court to have a jury trial under the authority of a specially trained judge. - Health courts utilizing a jury should provide juries with a specialized educational session on the basics of medical care delivery and the distinction between negligence and adverse outcomes as well as appropriate guidelines on the purpose of awarding non-economic damages. <p>Administrative Option</p> <ul style="list-style-type: none"> - An administrative system (e.g. established by a hospital or insurer) should include many of the same requirements that the AMA supports for a health court established within a jurisdiction’s standard judicial system. - Health court pilot programs established through an insurer or hospital should have jurisdiction over patients who choose to opt in to the system. <p>II. Health Court Judges</p> <p>Selection of Health Court Judges</p> <ul style="list-style-type: none"> - Health court judges should be appointed by a health 	

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		<p>court task force.</p> <ul style="list-style-type: none"> - The health court task force should be comprised of four physicians, four lawyers, and four laypersons. - The majority and minority leaders in each of the state’s legislative chambers should pick one member from each category (i.e., house majority leader would pick one physician, one lawyer, and one layperson for the task force. The house minority leader, the senate majority leader, and the senate minority leader would do the same.) - The health court task force chairmanship should rotate on an annual basis. - The majority and minority leaders in each legislative chamber should ask the state medical association for a list of health court task force candidates before making an appointment. - Governmental entities should adjust the term of a health court judge based on the length of terms in their state for other special courts. <p>Training for Health Court Judges</p> <ul style="list-style-type: none"> - Health court judges should complete a judicial training program which provides an overview of medical and legal issues that often arise in medical liability cases. - The curriculum should be established by the health court task force. - The medical portion of the training program should include both in-classroom clinical training and an internship whereby the judge “shadows” a physician in different health care settings. - States and other government bodies with an existing judicial training program should have this office administer the special training program for judges assigned to the health court. <p>III. Health Court Procedure</p> <p>Threshold for Patient Compensation</p> <ul style="list-style-type: none"> - Negligence must be proven for a patient to recover in a health court proceeding. <p>Damages</p> <ul style="list-style-type: none"> - Economic damages should not be limited. Injured parties should be fully compensated for their economic losses. - Non-economic damage awards should be established by a schedule. Consistent injuries should result in consistent non-economic damage awards based on the schedule. The health court task force should establish the schedule. - One option for the schedule is to base it on type/severity of the injury. Another option is to have the schedule link non-economic damages awards to the amount of economic damages included in the judgment. - Punitive damages, if allowed, should not be awarded unless the party alleging such damages meets the burden of producing clear and convincing evidence of oppression, fraud, malice, or the opposing party’s intent to do harm. - Health court judges should give jury instructions that provide clear delineations between the purposes of economic damages (for economic loss), non-economic damages (for pain and suffering), and punitive damages 	

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		<p>(for punishment to prevent future bad behavior). The instructions should also distinguish the different burden of proof needed for punitive damages.</p> <ul style="list-style-type: none"> - Future damages should be paid on a periodic basis as authorized by a health court. <p>Other Procedural Issues</p> <ul style="list-style-type: none"> - Health courts should be designed to resolve claims within one year from the filing date. - Health courts should limit attorney’s fees to maximize the award to the patient. - Collateral payment sources should be admissible as evidence in a health court proceeding. - Health court damage awards should include mandatory offsets for collateral payments for the same injury. - An affidavit/certificate of merit should be a prerequisite to filing a medical liability case before a health court. - A pre-trial screening panel should be utilized prior to the start of a trial before a health court. - The statute of limitations in a health court should be two years from the act or omission. - The period for suspending the application of state statutes of limitations for minors should be no more than six years after birth. The statute should include a three-year statute of repose from manifestation as well for minors. - In a health court proceeding, statements of sympathy, apology or regret made by a health care provider or their staff to an alleged victim or family of the victim relating to the discomfort, pain, suffering, injury, or death resulting from an unanticipated outcome of medical care should be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. <p>IV. Medical Error Reporting</p> <p>Medical Error Reporting</p> <ul style="list-style-type: none"> - The AMA continually strives to advance efforts to improve patient safety through educational activities and all other available means to discover and promote ‘best practices’ in the delivery of health care services. Toward this end, a health court system should encourage the reporting of medical errors. - The reporting system should be non-punitive, and it should be confidential and not subject to discovery in legal proceedings. - The medical error reporting system should collaborate with the Patient Safety Organization (PSO) (which will be established pursuant to the federal Patient Safety and Quality Improvement Act of 2005) in its state or region to encourage the efficient reporting and analysis of the data. <p>V. Experts</p> <p>Court Appointed Medical Experts</p> <ul style="list-style-type: none"> - The health court task force should maintain a list of qualified medical experts from which a judge may select to help clarify or interpret medical testimony given in legal proceedings. - A health court judge should use and rely on the testimony of a court appointed medical expert. 	

Policy Number	Title	Text	Recommendation
		<p>- A court appointed medical expert must, at a minimum, meet the same qualifications as the medical experts who testify on behalf of a party in the presiding lawsuit.</p> <p>Party Expert Witnesses</p> <ul style="list-style-type: none"> - Health courts should only allow medical expert witnesses to testify if the expert witness is licensed as a doctor of medicine or osteopathy. - An expert witness should be trained and experienced in the same field as the defendant or has specialty expertise in the disease process or procedure performed in the case. - An expert witness should be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards. - An expert witness should, within five years of the date of the alleged occurrence or omission giving rise to the claim, be in active medical practice in the same field as the defendant, or have devoted a substantial portion of his time teaching at an accredited medical school, or in university-based research in relation to the medical care and type of treatment at issue. - A person who testifies as an expert witness in a health court should be deemed to have a temporary license to practice medicine in the state for the purpose of providing such testimony and should be subject to the jurisdiction of the state medical board. <p>VI. Review and Sunset</p> <p>Review</p> <ul style="list-style-type: none"> - The health court task force should be charged with reviewing the health court program on an ongoing basis. They should issue quarterly reports, open to the public, on claims filed, decisions rendered, claims paid, and claims resulting in no payment. <p>Sunset</p> <ul style="list-style-type: none"> - The health court task force may recommend to the governor and the legislative leaders that the health court system should be sunset if it is not financially viable or does not result in a more balanced and fair process. - Given that the costs are unknown and could potentially be charged to physicians, a health court system should include appropriate funding from government or foundation sources to protect participants from significant financial losses based on their participation under a health court format rather than the traditional medical liability system. <p>Citation: (BOT Rep. 15, A-07)</p>	

Policy Number	Title	Text	Recommendation
H-435.973	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	(1) Medical Expert Witness Testimony: Courts should admit into evidence only expert medical testimony that is shown through a proper legal foundation to be based on (a) widely accepted theories of medical science or (b) theories that are supported by a respectable minority of experts in the field at issue. (2) Implementation of the “Loser Pays” Rule in Medical Liability Litigation: Responsibility for a prevailing party’s legal expenses, including attorney fees, should not be shifted to a losing party in medical liability litigation unless (a) some provision is made for retrieving fees owed to a prevailing party from the losing party’s attorney in the event the losing party has no available assets; (b) some provision is made to calculate fees owed to a plaintiff’s attorney on the basis of the reasonable value of time expended, regardless of the existence of a contingency fee arrangement; (c) the rule is adopted that no losing party will be required to pay expenses including legal fees that exceed his or her own bill for such goods or services; and (d) other efforts are made as necessary to insure that the “loser pays” disincentive to pursue litigation applies equally to all parties. (3) Punitive Damages Awards: Punitive damages in medical liability cases should not be awarded unless the party alleging such damages meets the burden of producing clear and convincing evidence of the opposing party’s intent to do harm. Citation: (BOT Rep. CC, I-91; Reaffirmed: BOT Rep. 9, I-99; Reaffirmed: BOT Rep. 13, A-07)	Retain – This policy remains relevant.
H-440.869	Establishment of Model Legislation to Develop State Commission/ Taskforce to Eliminate Racial and Ethnic Health Care Disparities	Our AMA will develop model legislation and encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state. Citation: (Res. 914, I-07)	Retain in part – The directive to develop model legislation has been achieved. The remainder of this policy remains relevant.
H-440.870	Amending Child Restraint Laws	Our AMA supports: (1) federal legislation that increases law enforcement standards for child safety seat use in the United States; and (2) state and federal legislation that updates child car seat violation codes from a secondary to primary law. Citation: (Res. 913, I-07)	Retain – This policy remains relevant.
H-440.874	Support of Legislation Regarding Global and Domestic Tuberculosis Control	Our AMA supports federal legislation to increase resources for global and domestic TB control. Citation: (Res. 227, A-07)	Retain – This policy remains relevant.
H-450.939	Activities of the National Quality Forum	Our AMA will: (1) continue to advocate for the Physician Consortium for Performance Improvement as the measure developer for physician-level performance measurement; (2) continue to monitor the National Quality Forum’s (NQF) activities to ensure physician representation and involvement in all activities and leadership; and (3) oppose any efforts to expand the NQF’s mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement’s principal role in the measure development process. Citation: (BOT Rep. 1, I-07)	Retain – This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-450.940	National Quality Forum	Our AMA opposes any efforts to expand the National Quality Forum's (NQF) mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement's principal role in the measurement development process and will report on the ongoing activities of the NQF at the 2007 Interim Meeting. Citation: (Res. 230, A-07)	Rescind – The report referenced in this policy was completed and submitted to the HOD at the 2007 Interim Meeting as BOT Rep. 1. The recommendation in the report was adopted as Policy H-450.939, which supersedes this policy.
H-450.944	Protecting Patients' Rights	Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives. Citation: (Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07)	Retain – This policy remains relevant.
H-450.962	National Committee for Quality Assurance	The AMA: (1) promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies; and (2) will develop policy and medically appropriate guidelines for review of physician offices as promulgated by NCQA. Citation: (BOT Rep. 12, A-95; Reaffirmation I-96; Reaffirmed: CSAPH Rep. 3, A-07)	Retain in part – Clause 1 remains relevant. The AMA does not develop guidelines for review of physicians' offices so clause 2 should be rescinded.
H-450.964	National Committee for Quality Assurance	The AMA believes that the National Committee for Quality Assurance (NCQA) is not an appropriate organization to determine criteria for physician credentialing. The AMA: (1) advocates for appropriate changes in the NCQA policies, standards, and accreditation procedures that are consistent with AMA policy (Reaffirmed in lieu of Res. 701, I-94); (2) urges NCQA to study ways of modifying its standards and accreditation procedures to reduce the potential burdens placed on physicians and their employees in responding to the on-site office review requests made by managed care organizations; (3) urges NCQA to ensure that managed care organizations are prohibited from requesting and reviewing medical records of patients who are not enrollees of the health plan of the managed care organization being surveyed by NCQA; (4) urges NCQA to develop means of involving practicing physicians in NCQA's accreditation processes; and (5) urges NCQA to include physician satisfaction surveys of practicing physicians participating in managed care organizations as an additional measure of assessing the quality of managed care organizations under NCQA's accreditation processes. Citation: (BOT Rep. 6, A-94; Reaffirmed by Sub. Res. 722, I-96; Amended by Res. 710, A-97; Reaffirmed: CSAPH Rep. 3, A-07)	Rescind – The NCQA does not do physician credentialing, and therefore, this policy is no longer relevant.

Policy Number	Title	Text	Recommendation
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." Citation: (Res. 120, A-07)	Retain – This policy remains relevant.
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. Citation: Res. 701, I-07)	Retain – This policy remains relevant.
D-130.982	EMTALA - Major Regulatory and Legislative Developments	Our AMA: (1) continue to work with 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. Citation: (BOT Rep. 17, I-02; Reaffirmation A-07)	Retain in part – Clauses (1) and (4) should be removed since the Health and Human Services Advisory Committee on Regulatory Reform is no longer operational and HHS did establish an EMTALA Technical Advisory Group, although its charter ended in 2007. Clauses 2 and 3 can be retained.
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. Citation: (Res. 417, A-07)	Retain – This policy remains relevant.
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. Citation: (Res. 114, A-07)	Retain – This policy remains relevant.

Policy Number	Title	Text	Recommendation
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. Citation: (Res. 930, I-07)	Retain – This policy remains relevant.
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. Citation: (Res. 925, I-07)	Retain – This policy remains relevant.
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)	Rescind – The Medicare physician payment update problem was fixed with the Medicare Access and CHIP Reauthorization Act of 2015.
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’ Medicare multiple surgery reduction policy by reducing which reduces 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. Citation: (CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07)	Retain in part – The Centers for Medicare & Medicaid Services has implemented multiple surgery reduction policies, so clause (4) should be modified accordingly.

Policy Number	Title	Text	Recommendation
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. Citation: (Res. 444, A-07)	Retain – This policy remains relevant.

APPENDIX 2 - AMA Policies Superseding Policies Recommended for Rescission

H-175.976, “Physician Protections in Fraud Data Bank Program”

Our AMA will take all necessary actions to oppose and rescind the Health Care Integrity and Protection Data Bank. If not possible to repeal the establishment of the data bank, the AMA should take steps to protect the legal due process rights of practitioners. (Sub. Res. 803, A-99; Reaffirmation I-07)

H-355.975, “Opposition to the National Practitioner Data Bank”

1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank.
2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank.
3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office.
4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank.
5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;
6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.
8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates.

H-355.977, “Reporting of Resident Physicians to the National Practitioner Data Bank”

1. Our AMA: (A) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements.
2. Our AMA: (A) fully supports the mandatory and prompt notification of residents by the appropriate hospital authority when they are named along with a hospital and/or others in the hospital in malpractice suits; (B) opposes the inclusion in the National Practitioner Data Bank of information on liability payments made on behalf of residents named in malpractice suits for incidents that occur during the required supervised activities of their residency training; (C) seeks the immediate suspension of the policy whereby information on residents named in malpractice suits for incidents which occur during the required supervised activities of their residency training is reported to the National Practitioner Data Bank when liability payments are made on their behalf; and (D) will work with the Association of American Medical Colleges and other interested parties to reinvigorate its efforts to successfully change National Practitioner Data Bank policy through legislative or other means in accordance with this policy.
3. Our AMA will 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.

H-355.990, “National Practitioner Data Bank”

(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner’s self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than \$30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB’s first year of operation to the AMA by July 1992. (3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.

23. ANTI-HARASSMENT POLICY

Reference committee hearing: see report of [Reference Committee F](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
*See Policy H-140.837***

Though the American Medical Association has in place a comprehensive anti-harassment policy regarding AMA employees, the Board of Trustees has recently become aware that no such policy exists regarding the House of Delegates, AMA sections, AMA councils, or other AMA governance entities (collectively, the “AMA Entities”). To ensure consistency throughout our AMA, the Board has reviewed this issue and presents the following report and recommendations to the HOD.

DISCUSSION

Our AMA has strong policies against discrimination and harassment in all forms. In particular, Human Resources Policy 015 (Anti-Harassment Policy) provides in pertinent part:

It is the policy of the AMA that any type of harassment of employees or applicants for employment by managers, supervisors, co-workers, other employees, or agents of AMA or non-employees (including vendors, customers or members) in the workplace is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance environment for unlawful conduct at all locations where AMA employees are conducting AMA business.

This policy includes the following definitions:

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive work environment; (2) has the purpose or effect of unreasonably interfering with an individual’s work performance; or (3) otherwise adversely affects an individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or circulated in the workplace.

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature an explicit or implicit condition of continued employment;
- making submission to, or rejection of, such conduct the basis for employment decisions; and
- creating an intimidating, hostile or offensive work environment or otherwise unreasonably interfering with an individual's work performance by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and physical contact such as pinching or brushing against another person.

Consistent with the above Human Resources Policy 015 and the AMA's zero tolerance policy regarding harassment, all members of the Board of Trustees are required to complete the same anti-harassment training that AMA staff are asked to complete, namely, the AMA's "Preventing Harassment for Members of AMA Leadership Bodies" training, which is conducted by means of an online training module.

Additionally, at the first session of each HOD meeting, as provided in the HOD Reference Manual, delegates are asked to ratify a code of conduct that reaffirms a commitment to be courteous, respectful and collegial in the conduct of HOD business, and delegates are reminded of their personal responsibility regarding courteous and respectful dealings in all interactions with other delegates and with AMA staff at HOD meetings, including social events apart from HOD meetings themselves.

While the above code of conduct and commitment to be courteous, respectful and collegial in the conduct of HOD business implicitly forbids any type of harassment of other delegates or AMA staff at meetings of any AMA Entity, the Board notes that neither the HOD Reference Manual nor any other existing AMA Policy includes an explicit anti-harassment policy regarding the AMA Entities. The Board further notes that AMA Human Resources Policy 015 (Anti-Harassment Policy) does not explicitly apply to the AMA Entities (see also Appendix for AMA policy and guidelines). The Board's recommendations in this report address this issue.

Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the House of Delegates adopt the following recommendations, and that the remainder of this report be filed:

1. That our American Medical Association adopt the following policy:

Anti-Harassment Policy Applicable to AMA Entities

It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity,

national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. That the Board of Trustees establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.

APPENDIX - AMA Policy

H-65.987 Gender Exploitation in the Workplace

H-295.955 Teacher-Learner Relationship in Medical Education

H-295-964 Enforcement of AMA Policy on Sexual Exploitation and Harassment

H-295-970 Sexual Harassment and Exploitation between Medical Supervisors and Trainees

H-525.998 Women in Organized Medicine

E-3.08 Sexual Harassment and Exploitation between Medical Supervisors and Trainees

D-295-962 Prevention of Harassment and Discrimination of Women in Medicine

D-525.996 Prevention of Harassment and Discrimination of Women in Medicine

AMA Guidelines

American Medical Association Guidelines for Preventing and Addressing Harassment in the Medical Profession

24. PROTECTING PATIENT ACCESS TO HEALTH INSURANCE COVERAGE, PHYSICIANS, AND QUALITY HEALTH CARE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2016 Interim Meeting, the House of Delegates (HOD) adopted Policy D-165.935, “Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care,” which called on our American Medical Association (AMA) to “(a) actively engage the new Administration and Congress in discussions about the future of health care reform, in collaboration with state and specialty medical societies, emphasizing our AMA’s extensive body of policy on health system reform; and (b) craft a strong public statement for immediate and broad release, articulating the priorities and firm commitment to our current AMA policies and our dedication in the development of comprehensive health care reform that continues and improves access to care for all patients.” The adopted policy also called on our AMA Board of Trustees (BOT) to report back to the HOD at the 2017 Annual Meeting. This report fulfills that directive.

ENGAGEMENT WITH CONGRESS AND THE TRUMP ADMINISTRATION

At the direction of the HOD and in anticipation that a top priority for the Trump Administration and the Republican-led Congress would be to repeal the Affordable Care Act (ACA) in 2017, the AMA released a document entitled “[AMA Vision on Health Reform](#),” on November 15, 2016, during the AMA’s Interim Meeting. This document, based on decades of policy developed by the HOD, reaffirms the AMA’s commitment to improving health insurance coverage and health care access so that patients receive timely, high quality care, preventive services, medications, and other necessary treatments, and outlines a number of health system reform objectives that should be considered by policymakers in making changes to the ACA. On January 3, 2017, the AMA sent a [letter](#) to congressional leadership affirming our ongoing commitment to health system reform and to the ACA’s primary goal of making high quality, affordable health care coverage accessible to all Americans. The letter also stated that “it is essential that gains in the number of Americans with health insurance coverage be maintained.” The letter attached [a summary](#) of the AMA’s Vision on Health Reform and urged policymakers to provide a detailed outline of any ACA replacement plan before any vote to repeal the ACA. These documents were subsequently shared with the new Trump Administration in January.

The 115th Congress began with an ambitious timetable through the passage of a Budget Resolution in January that instructed relevant committees—i.e., the House Energy and Commerce Committee, and the House Ways and Means Committee—to craft ACA repeal provisions to be included in a budget reconciliation bill. Under the Senate procedural rules for reconciliation, only a simple majority is required for approval; however, procedural rules for reconciliation bills prevent inclusion of provisions that are primarily policy issues that do not have a significant impact on federal spending. House and Senate Republican leaders were under pressure to act quickly on campaign promises to repeal the ACA and to do so before health insurers’ rate filings and applications to participate in the exchanges for 2018 were due in the spring. They also were, and continue to be, under pressure to resolve the future of the ACA so that other priorities, such as tax reform, an infrastructure initiative, and 2018 federal budget matters, could be addressed. During this period, AMA leadership and staff actively engaged with congressional leaders and the Administration to convey the AMA’s priorities and principles for health reform. The AMA also worked closely with Federation members and held state and specialty CEO meetings to receive input and discuss areas of general consensus on health system reform objectives. Several workgroups comprised of representatives from state and medical specialty societies were formed to develop recommendations and principles on regulatory relief, insurance market reforms, and Medicaid. These workgroups are ongoing.

On March 6, 2017, the House Republican leadership introduced the American Health Care Act (AHCA) (H.R. 1628), legislation to repeal and replace several major provisions of the ACA. The bill was introduced in two parts due to jurisdictional issues, and was marked up by the House Energy and Commerce Committee and the House Ways and Means Committee on March 8. However, due to a split in policy approaches between conservative House Republican members and more moderate and centrist members, leadership struggled to attract sufficient votes to bring the bill to the floor for a vote. Facing increased pressure from the White House to schedule a vote and after several substantive amendments were made to bring several conservatives on board, the House of Representatives

narrowly passed an [amended version of the AHCA](#) on May 4 by a vote of 217 to 213. House Democrats unanimously opposed the legislation. Twenty Republicans also voted against the legislation.

Immediately after the bill's initial introduction and following the introduction of various amendments, the AMA's advocacy team reviewed and evaluated the bill's provisions to determine their impact on patients, physicians, and the broader health care system. The AMA advocacy team's analysis of the AHCA was reviewed by the Council on Legislation on March 7 and again on March 21, and the BOT adopted the Council's recommendation that the AMA not support the AHCA, and urge Congress to seek health system reforms consistent with the AMA's core principles to make high-quality, affordable health care coverage accessible to all Americans. Key in the determination to oppose the AHCA was that it failed to meet the AMA's core principles on health system reform that include ensuring that individuals currently covered do not become uninsured and taking steps toward coverage and access for all Americans, and to ensure that low- and moderate-income patients are able to secure affordable and adequate coverage. With respect to Medicaid, the legislation did not meet the AMA's principle to ensure that Medicaid, CHIP, and other safety-net programs are maintained and adequately funded. Last minute changes made to the bill that would provide additional funds for high-risk pools and other purposes for states that obtain waivers from critical consumer protections provided under current law failed to remedy the underlying problems with the bill. A [summary](#) of the AHCA as passed by the House is posted on the AMA's website.

In a [letter](#) to the leadership of the House Energy and Commerce Committee and Ways and Means Committee dated March 7, the AMA shared its views on the draft AHCA, stating that "while we agree that there are problems with the ACA that must be addressed, we cannot support the AHCA as drafted because of the expected decline in health insurance coverage and the potential harm it would cause to vulnerable patient populations." On March 8, the AMA released a [press release](#) announcing the transmittal of the letter. The AMA sent another [letter](#) to House leadership on March 22 expressing its opposition to the AHCA, and released another [press release](#). On March 13, after the nonpartisan Congressional Budget Office (CBO) released its analysis of the bill, the AMA issued a [press release](#) that stated that the CBO's estimate underscored the AMA's concerns about the AHCA: "If this bill were to become law, CBO projects 14 million Americans who have gained coverage in recent years could lose it in 2018. For the AMA, that outcome is unacceptable. While the Affordable Care Act was an imperfect law, it was a significant improvement on the status quo at the time, and the AMA believes we need continued progress to expand coverage for the uninsured. Unfortunately, the current proposal—as the CBO analysis shows—would result in the most vulnerable population losing their coverage." On April 27, a [third letter](#) was sent to House leadership urging Congress to oppose the amended legislation. All of the AMA letters and press releases on the AHCA received widespread media attention. In addition, during March, April, and May, AMA staff held several conference calls to update the Federation on the details of the legislation, receive input from Federation members, and share AMA's concerns and position on the legislation.

Consideration of the AHCA has now moved to the U.S. Senate. As this report was being written on May 17, it remains uncertain what approach the Senate will take with the bill, although most observers expect it to be substantially rewritten. Senate Majority Leader Mitch McConnell has appointed a working group comprised of 13 Senators to develop the Senate bill, which will need to meet the budget reconciliation rules as determined by the Senate Parliamentarian, and which will also have to meet the savings target set in the House bill. The CBO is not expected to issue its revised analysis of the legislation as passed by the House until the week of May 22, which most likely means that bill language will not be developed and available until sometime in June. On May 15, the AMA sent a [letter](#) to Senate Majority Leader Mitch McConnell and Senate Democratic Leader Charles Schumer reaffirming the AMA's principles that we believe should guide consideration of any changes to the ACA considered by the Senate. As the Senate takes up consideration of the AHCA or develops new legislation, the AMA's discussions with lawmakers will continue to be guided by the AMA's [Vision on Health Reform](#) document. The AMA will continue to engage and update the Federation as developments proceed in the Senate.

GRASSROOTS AND MEDIA ACTIVITIES

On March 13, the AMA launched a new microsite aimed at encouraging physicians and patients to join the AMA's fight to increase access to affordable, meaningful coverage for everyone in our nation. Patientsbeforepolitics.org is an interactive site that provides physicians and patients with the latest information on health care reform legislation moving through Congress, as well as the AMA's current efforts to help shape the future of U.S. health care. The site features an easy way for both patients and physicians to contact members of Congress—urging them to protect patients currently insured, enable low and moderate income people to secure meaningful coverage, and maintain

Medicaid and other safety net programs. The site also includes numerous AMA policy briefs and Council on Medical Service reports on different aspects of health insurance and market reform, Medicaid, and additional AMA objectives for health system reform.

In addition to the press releases and op-eds previously mentioned in this report, the AMA's health reform communication activities have included numerous stories published in [AMA Wire](#), as well as op-eds published in [Modern Healthcare](#), [Philadelphia Inquirer](#), [Detroit News](#), and [KevinMD](#). Moreover, the AMA's social media advocacy campaign experienced record exposure around the AHCA. In March, a tweet conveying the AMA's lack of support for the proposed health care plan was seen by over one million people, and a tweet that included a visual quote from AMA CEO James L. Madara, MD, that urged our followers to contact their representatives through the AMA's health reform microsite, [patientsbeforepolitics.org](#), grew in popularity and to date has been seen more than 4.6 million times, a record amount of exposure for a single AMA tweet.

ENGAGEMENT WITH FEDERATION AND PATIENT AND PROVIDER GROUPS

In addition to the AMA's engagement with the Federation through meetings and conference calls, the AMA also has collaborated with an array of patient advocacy groups, hospitals, and other health care stakeholders in raising core objections to the AHCA's underlying approach to fixing the imperfections of the ACA. On March 16, the AMA held a [news conference](#) in Washington, DC, along with three major organizations representing patients—the American Cancer Society Cancer Action Network (ACS-CAN), the American Diabetes Association, and the American Heart Association—to express joint concerns over the AHCA. On April 13, the AMA and seven other organizations representing family physicians, hospitals, businesses, employers, and health insurers, sent letters to the [Trump Administration](#) and to [Congressional leaders](#) expressing concerns over continued funding for the cost-sharing reduction (CSR) program under the ACA to help lower health care costs for low- and moderate-income individuals. The AMA also collaborated on a [joint op-ed](#) on the CSR issue with the American Heart Association and ACS-CAN, which was published in the *Hill* newspaper on April 26. Additional engagement with physicians and patients occurred through six physician focus groups in March and April—in Philadelphia, Chattanooga, and Phoenix—that focused on AMA health system reform principles and messaging and broader health system and delivery issues. In April, patient-physician roundtables were convened in Denver and Atlanta in collaboration with the state medical societies and AARP, ACS-CAN, and the American Heart Association, to gather additional input on the ACA's successes and shortcomings. The AMA's outreach to the Federation, patient groups, and other provider and health organizations will continue as the debate over health system reform proceeds in the Senate.

25. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES: FIVE-YEAR REVIEW

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policy D-600.984.

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2017 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2017 Annual Meeting:

Academy of Physicians in Clinical Research

American Association of Hip and Knee Surgeons
 American Society for Reproductive Medicine
 American Society of General Surgeons
 American Society of Neuroimaging
 American Thoracic Society
 College of American Pathologists
 Congress of Neurological Surgeons
 Contact Lens Association of Ophthalmologists, Inc.
 International College of Surgeons – US Section
 Society for Cardiovascular Angiography and Interventions
 Society for Investigative Dermatology, Inc.
 Society of Interventional Radiology
 United States and Canadian Academy of Pathology

The American Association of Hip and Knee Surgeons, American Society of Neuroimaging and the Society of Interventional Radiology were reviewed at this time because they failed to meet the requirements of the review in 2016.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, Inc., International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, Society for Investigative Dermatology, Inc., Society of Interventional Radiology, and United States and Canadian Academy of Pathology meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicated that: Academy of Physicians in Clinical Research, American Association of Hip and Knee Surgeons, American Society of General Surgeons and American Society of Neuroimaging did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the HOD.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That the American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, Inc., International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, Society for Investigative Dermatology, Inc., Society of Interventional Radiology, and United States and Canadian Academy of Pathology retain representation in the American Medical Association House of Delegates.
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.50, the Academy of Physicians in Clinical Research and the American Society of General Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Association of Hip and Knee Surgeons and American Society of Neuroimaging not retain representation in the House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

<u>Organization</u>	<u>AMA Membership of Organization's Total Eligible Membership</u>
Academy of Physicians in Clinical Research	97 of 257 (38%)
American Association of Hip and Knee Surgeons	346 of 2,250 (15%)
American Society for Reproductive Medicine	983 of 2,933 (34%)
American Society of General Surgeons	65 of 247 (26%)
American Society of Neuroimaging	82 of 267 (30%)
American Thoracic Society	1,581 of 8,056 (20%)
College of American Pathologists	1,497 of 10,514 (14%)
Congress of Neurological Surgeons	774 of 3,470 (22%)
Contact Lens Association of Ophthalmologists, Inc.	52 of 179 (22%)
International College of Surgeons – US Section	263 of 737 (36%)
Society for Cardiovascular Angiography and Interventions	420 of 2,013 (21%)
Society for Investigative Dermatology, Inc.	310 of 860 (36%)
Society of Interventional Radiology	680 of 3,255 (20%)
United States and Canadian Academy of Pathology	1,303 of 7,080 (18%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

- 8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1 To cooperate with the AMA in increasing its AMA membership.
- 8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REPORT OF THE SPEAKERS

The following report was presented by Susan R. Bailey, MD, Speaker; and Bruce A. Scott, MD, Vice Speaker.

1. RECOMMENDATIONS FOR POLICY RECONCILIATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," states in relevant part that the Speakers should "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers believe that such housekeeping is a valuable exercise given the breadth and volume of our AMA's policy database, and while none of the changes recommended herein is particularly far reaching, each will make a modest improvement in its own right.

Suggestions on other policy statements that are thought to be outdated or needing revision for any other reason should be sent to hod@ama-assn.org. That address may also be used to contact your Speakers on any House-related matter.

RECOMMENDED RECONCILIATIONS

Policies to be retitled

1. Policy H-255.980, "Foreign Medical Graduate Examination in Medical Sciences Scores not Sole Criteria for Residency Selection," uses a title that is misleading and requires minor edits for better flow.

The policy will be retitled "USMLE Scores not Sole Criteria for Residency Selection," as that reflects the content of the policy and the fact that the FMGEMS exam is no longer administered. Additional changes are made for style and are non-substantive.

~~The~~ Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; ~~and~~ (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; ~~and~~ (3) ~~Our~~ ~~AMA~~ reaffirms policy that residency appointments should be made solely on the basis of the individual applicant's merit and qualifications.

2. The title of Policy H-383.998, "Impact of the NLRB Ruling in the Boston Medical Center Case," derives from a resolution at the 1999 Annual Meeting. While the policy itself remains relevant, the title is unrelated to the content, is effectively moot, and could make finding the policy difficult. The policy will be renamed as follows, with the text of the policy unchanged.

Policy H-383.998, "Resident Physicians, Unions, and Organized Labor"

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

References to completed directives to be deleted from policy statements

The following changes will delete references to reports that have been completed but otherwise do not affect the policy.

3. Policy D-310.977, "National Resident Matching Program Reform," includes a call for our AMA to study common reasons for failures to match (§14 of that policy). The report was completed in Council on Medical Education Report 3-A-16. That specific request for a report is to be rescinded.

Our AMA: (1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process; (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match; (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match; (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises; (5) will 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; (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process; (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant; (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas; (10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers; (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program; ~~(14) will study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match;~~ (15) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions; and (16) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.

4. The last paragraph of Policy H-110.987, "Pharmaceutical Cost," calls for a report that was delivered to the House this past November in Board of Trustees Report 10-I-16. That portion of the policy will be stricken as your Board has indicated that future reports will keep the HOD apprised of ongoing AMA advocacy and grassroots efforts to help put forward solutions to make prescription drugs more affordable for all patients.

H-110.987, "Pharmaceutical Cost"

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC

and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients ~~and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting.~~

5. Policy D-405.988, "The Preservation of the Private Practice of Medicine," includes a call for a report at the 2015 Annual Meeting. That report was delivered in Board of Trustees Report 16 at that meeting. The clause calling for the report will be removed from the policy. Our AMA's ongoing efforts in the Professional Satisfaction and Practice Sustainability (PS2) focus area provide the resources called for in the policy.

Policy D-405.988, "The Preservation of the Private Practice of Medicine"

Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice, ~~with a progress report at the 2015 Annual Meeting;~~ and (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.

Policies to be combined with older policy rescinded

6. Policy D-95.974, "Study OTC Availability of Naloxone," directed our AMA to report at the 2016 Annual Meeting on the stated topic. Board of Trustees Report 22-A-16 provided the report and developed Policy H-95.932. To reconcile policy, the first paragraph of Policy D-95.974 should be incorporated into the newer policy (H-95.932), and as the second paragraph of Policy D-95.974 has been accomplished, the policy should be rescinded. Policy H-95.932 would therefore read as follows (with the language taken from D-95.974 underscored):

H-95.932, "Increasing Availability of Naloxone"

1. Our AMA supports legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone. 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients. 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing. 5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law. 6. Our AMA supports efforts to encourage individuals who are

authorized to administer naloxone to receive appropriate education to enable them to do so effectively. 7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.

~~D-95.974, "Study OTC Availability of Naloxone"~~

~~1. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration. 2. Our AMA will study and report back at the 2016 Annual Meeting on ways to expand the access and use of naloxone to prevent opioid-related overdose deaths.~~

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.