REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–28, were presented by Stephen R. Permut, MD, JD, 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, 2015 and 2014 and the Independent Auditor's report have been included in a separate booklet, titled "2015 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 Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

The Board of Trustees and the Specialty and Service Society (SSS) considered the application of the American Society of Dermatopathology for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The application was first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The application was considered using criteria developed by the Council on Long Range Planning and Development and adopted by the House Policy G-600.020. A summary of the guidelines is attached under Exhibit A.

Organizations seeking admission are asked to provide appropriate membership information to the AMA. That information for the American Society of Dermatopathology was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

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 criteria.

Before a society is eligible for admission to the House of Delegates, it must participate in the SSS for three years. The American Society of Dermatopathology was admitted to the SSS in 2013 and has been a member in good standing since then.

Review of the materials and discussion during the SSS meeting at the 2015 Interim Meeting indicated that American Society of Dermatopathology meets the criteria for representation in the House of Delegates.

RECOMMENDATIONS

The Board of Trustees recommends that the American Society of Dermatopathology be granted representation in the AMA House of Delegates and the remainder of this report be filed.

Exhibit A - Guidelines for Representation in and Admission to the House of Delegates: National Specialty Societies

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; or
   - 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.

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.

Exhibit B - Summary Membership Information

	AMA Membership of Organization's Total Eligible Membership
American Society of Dermatopathology	344 of 1,215 (28%)

3. 2015 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 2015.

American Medical Association
Grants & Donations
For the Year Ended December 31, 2015
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through Medical College of Wisconsin)	Pediatric Measurement Center of Excellence	$ 37
Centers for Disease Control and Prevention (subcontracted through Cleveland Clinic)	eMeasure Development & NQF Support-Hemolysis Measure	6
Centers for Disease Control and Prevention (subcontracted through National Association of Chronic Disease Directors)	Diabetes Prevention Program	117
Centers for Medicare & Medicaid Services (subcontracted through Brandeis University)	Episode Grouper for Medicare Project	161

American Medical Association
Grants & Donations
For the Year Ended December 31, 2015
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Medicare & Medicaid Services (subcontracted through Mathematica Policy Research, Inc.)	Electronic Clinical Quality Measures	399
Centers for Medicare & Medicaid Services (subcontracted through Mathematica Policy Research, Inc.)	Quality Measures for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees	6
National Institute on Drug Abuse (subcontracted through Booz Allen Hamilton, Inc.)	Substance Use Screen and Brief Counseling Composite Electronic Clinical Quality Measure Development	28
Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)	Providers' Clinical Support System for Opioid Therapies	34
Government Funding		**788**
American Academy of Otolaryngology-Head and Neck Surgery Foundation	Quality Measures for Acute Otitis Externa / Otitis Media with Effusion Measures	57
American College of Cardiology Foundation	Quality Measures for Peripheral Arterial Disease and Cardiac Rehabilitation	32
American College of Cardiology Foundation	NQF Cardiovascular Measurement Endorsement Maintenance Cycle	9
American College of Emergency Physicians	Qualified Clinical Data Registry Quality Measures	197
American College of Emergency Physicians	Measure Development: Up to 4 Effectiveness, Overuse, Appropriateness Measures to Enhance Emergency Care	48
American College of Emergency Physicians	Post-National Quality Forum Submission Report and Representation	8
American College of Rheumatology	eMeasure Development for Glucocorticoid-Induced Osteoporosis	23
American College of Surgeons	Quality Measures for Perioperative Care	1
American Medical Association Foundation	Accelerating Change in Medical Education Conference	95
College of American Pathologists	Electronic Measure Specification and Testing for Pathology	56
CDC Foundation	Electronic Measure Specifications for Hepatitis C Measures	3
The Arnold P. Gold Foundation	Learning Environment Study Collaborative Research Project	5
Nonprofit Contributors		**534**
Educational Commission for Foreign Medical Graduates	International Medical Graduates Symposium	7
Eli Lilly and Company	Accelerating Change in Medical Education Conference	10
Elsevier Clinical Solutions	Accelerating Change in Medical Education Conference	10
Contributions less than $5,000	International Medical Graduates Symposium	7
Other Contributors		**34**
Total Grants and Donations		**$ 1,356**

4. AMA 2017 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

2017 Membership Year

The Board of Trustees recommends no change to the dues levels for 2017, 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, 2015. 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 2015 RESULTS

In 2015, 32 new activities were considered and approved through the corporate review process. Of the 32 projects recommended for approval, ten were conferences or events, one was an education or grant program, fifteen were collaborations, five were member service provider programs and one was an American Medical Association Foundation (AMAF) program (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 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 2015

Project No.	Project description	Corporations	Approval Date
	Conferences / Events		
22738	TEDMED and AMA Collaboration – AMA as a Global Institutional Partner at the TEDMED conference and co-branded event in Chicago.	TEDMED	7/7/2015

Project No.	Project description	Corporations	Approval Date
23386	Second National Summit on Health Care Price, Cost and Quality – AMA co-sponsorship at the Second National Summit on Health Care Price, Cost and Quality.	Robert Wood Johnson Foundation AARP, Inc. Academy Health Bipartisan Policy Center BlueCross Blue Shield Association California Association of Physician Groups (CAPG) Consumers Union Federation of American Hospitals (FAH) Healthcare Financial Management Association (HFMA) The Leapfrog Group National Committee for Quality Assurance (NCQA) National Partnership for Women & Families National Quality Forum (NQF) The Network for Regional Healthcare Improvement (NRHI) Pacific Business Group on Health (PBGH)	1/14/2015
23485	Harvard Personalized Medicine Conference – AMA as an associated partner at the Harvard Personalized Medicine Conference.	American Association for Respiratory Care (AARC) Personalized Medicine Coalition (PMC)	2/9/2015
23524	HIMSS & AMA Annual Conference Endorser Agreement – AMA involvement with and logo placement on HIMSS annual conference web site.	Health Information and Management Systems Society (HIMSS)	2/9/2015
23564	Alliance to Prevent the Abuse of Medicines Hill Briefing on Opioids – AMA as a sponsor of The Alliance to Prevent the Abuse of Medicines Hill Briefing on Opioids.	Alliance to Prevent the Abuse of Medicines CQ Roll Call US Chamber of Commerce	2/13/2015
23604	National Quality Forum Annual Conference Breakfast – AMA as a sponsor of the National Quality Forum annual breakfast meeting.	America's Health Insurance Plans American Hospital Association Health Management Associates National Quality Forum	2/24/2014
23719	AMA Sponsorship for Aspen Ideas Festival – AMA as a supporting sponsor of Spotlight Health, the health event at Aspen Ideas Festival, hosted by the Aspen Institute.	Aspen Ideas Festival The Aspen Institute Association of American Medical Colleges (AAMC) The Atlantic Autism Speaks Bill & Melinda Gates Foundation Consumer Reports Sinai Health System Spotlight Health Welltower, Inc. (formerly Healthcare REIT)	4/1/2015
24126	Health 2.0 & AMA Collaboration – AMA sponsorship package with Health 2.0 at Health 2.0's Annual Conference 2015 and a roundtable event in Chicago.	Health 2.0 LLC POMIET LLC	7/16/2015
24349	Change MedEd 2015 Sponsorship – External sponsorship for the AMA ChangeMedEd 2015 national conference.	Eli Lilly and Company Elsevier BC Genentech, Inc. Perdue Pharma L.P. Pfizer, Inc.	9/3/2015
24623	Electronic Health Record (EHR) Usability Workshop – AMA to co-host a meeting/workshop with EHRA to address EHR usability.	American College of Physicians (ACP) Electronic Health Record Association (EHRA) Health Information and Management Systems Society (HIMSS)	10/12/2015

Project No.	Project description	Corporations	Approval Date
	Education / Grant Activities		
24318	AMA-AAPL Physician Leadership Education – Cobranded physician leadership program on the health system, professional and personal development.	American Academy of Physician Leadership (AAPL)	9/11/2015
	Collaborations / Affiliations		
22893	AMA-Omada Virtual Diabetes Prevention Program Pilot – Collaboration between AMA and Omada Health, to test screening and referral for a virtual diabetes prevention program.	Omada Health	2/20/2015
23324	AMA- CVS Health Blood Pressure Collaboration – Pilot project in physician practice sites to test home blood pressure monitoring to better control hypertension.	CVS Health	1/22/2015
23325	AMA-John Hopkins Medicine (JHM) Collaboration with Quality Innovation Network -Quality improvement Organizations (QIN-QIOs) to improve blood pressure control – Collaboration on hypertension improvement tools and materials for primary care practices in multiple states.	Alliant GMCF Atlantic Quality Innovation Network (AQIN) atom Alliance Great Plains QIN HealthCentric Advisors HealthInsight Health Services Advisory Group (HSAG) Lake Superior QIN Mountain-Pacific Quality Health Qualis Health Quality Insights Telligen TMF Health Quality Institute Virginia Health Quality Center (VHQC)	1/7/2015
23566	AMA-Medstar Health EHR Usability Study – Medstar and AMA collaboration on an EHR usability study.	Medstar Health	2/20/2015
23567	AMA-AEHR EHR Survey Publication – Modification of an EHR survey publication.	American EHR Partner American Academy of Allergy and Immunology American Academy of Dermatology American Academy of Neurology American Academy of Physicians Assistants American College of Physicians American College of Rheumatology American College of Surgeons American Osteopathic Association of Medical Informatics American Psychiatric Association American Society of Clinical Oncology Infectious Diseases Society of America Renal Physicians Association Society of General Internal Medicine	2/20/2015
23616	AMA and AAPC market research study – Cobranding of a market research survey to determine the value of a certified coder to the efficiencies of business operations of a medical practice.	American Academy of Professional Coders (AAPC)	3/5/2015
23696	AMA Physician Satisfaction & Sustainability Practice Challenge –AMA collaboration with Health 2. 0 on a physician practice challenge.	Health 2.0 LLC	3/27/2015

Project No.	Project description	Corporations	Approval Date
23917	AMA and HSS/Merck Comprehensive Diabetes Prevention Program Collaboration (CDPP) – Demonstration project to address current barriers to enrollment in diabetes prevention programs.	Healthcare Services and Solutions LLC – A Subsidiary of Merck & Co., Inc. (HSS/Merck)	9/10/2015
23946	AMA Hypertension Improvement Collaboration with WCHQ – Collaboration to spread AMA - John Hopkins Medical developed Improving Health Outcomes: Blood Pressure (IHO:BP) program tools and resources to primary care practices in Wisconsin.	Wisconsin Collaborative for Healthcare Quality, Inc. (WCHQ)	5/29/2015
24120	Forward Health Group Inc. – Association of the AMA name with a joint research project with Forward Health Group.	Forward Health Group, Inc.	7/27/2015
24128	AMA and AHA collaboration on Blood pressure – Implementation program in six practice sites at the Grady Health System in Atlanta to reduce hypertension in African Americans.	American Heart Association	7/27/2015
24263	Collaboration with Optum – Licensing AMA content to Optum coding online products with AMA branding on the content module.	Optum	9/1/2015
24705	BCBSA Self- Measured Blood Pressure Collaboration – AMA/BCBSA collaboration on self-measured blood pressure monitoring for participating BCBS physicians.	Blue Shield Blue Cross Association (BSBCA)	11/6/2015
24792	Strategic Collaboration to Improve High Blood Pressure Control Rates – Agreement with the American Heart Association to co-lead national efforts to improve blood pressure control.	American Heart Association	11/6/2015
24967	Care Coordination Institute – Collaboration to evaluate and demonstrate evidence of a successful evaluation of the AMA-Johns Hopkins Medical Blood Pressure (IHO: BP) program.	Care Coordination Institute (CCI)	12/09/2015
24058	AMA Insurance Agency (AMAIA) Strategic Solutions Product Portfolio – Broaden the breadth and depth of products and services.	ACE American Insurance Company American International Group (AIG) American National Insurance Company American Bankers Insurance Company of Florida (Assurant) AXA Assistance USA AXA Equitable Insurance Company Careington International Corporation Cross Country Home Services (CCHS) Fairmont Specialty Bankers Life and Casualty Company Federal Insurance Company (Chubb Group of Insurance Companies) Hartford Life and Accident Insurance Company Hartville – US Fire Insurance Company International Medical Group (IMG) Kemper Corporation (Reserve National Insurance Company) Munich Reinsurance America, Inc. New Benefits Ltd New York Life Insurance Company	7/21/2015

Project No.	Project description	Corporations	Approval Date
		North American Casualty Group Protective Insurance Company Prudential Insurance Company of America Sirius International Insurance Corporation Transamerica Casualty Insurance Company Travel Guard (National Union Fire Insurance Company) United States Life Insurance Company	
24250	AMA Affinity Office Supply Program – AMA Affinity program for office supplies.	Office Depot	8/31/2015
24454	AMA Affinity Unsecured Loan Program – AMA Affinity program for unsecured loans.	First National Bank of Omaha	9/24/2015
24483	AMA Affinity Computer Discount Service Program – AMA Affinity program for discounts on computer equipment.	Lenovo, Inc.	9/29/2015
24810	AMA Affinity Appliance Program – AMA Affinity program for office appliances.	Whirlpool Corporation	11/20/2015
	AMA Foundation Programs		
23455	AMAF Scholarship Donations – Scholarship grants for minority medical students.	Physician Loans d/b/a Tower Mortgage Corporation	1/28/2015

6. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2006 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
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 the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation'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 1 - Recommended Actions on 2006 House Policies

Policy Number / Title	Text	Recommendation
H-100.966 Tracking and Punishing Distributors of Counterfeit Pharmaceuticals	Our AMA supports legislation making the production and distribution of counterfeit pharmaceuticals a felony.	Retain – This policy remains relevant.
H-100.972 Misuse of the DEA License Number	Our AMA: (1) affirms its opposition to use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe the substance; and will explore measures to discourage or eliminate the use of physicians' DEA license numbers as numerical identifiers in insurance processing and other data bases, either through legislation, regulation or accommodation with organizations which currently insist on collection of this sensitive data; (2) seeks to have its proposed legislation introduced, which would limit the use of DEA numbers to those federal and state entities that use the number to oversee and enforce the law regarding the manufacture, distribution, and dispensing of controlled substances; and (3) continues to advocate for the adoption of the AMA's Medical Education number as the unique identifier for physicians.	Retain – This policy remains relevant.
H-100.982 Confidentiality of Drug Enforcement Agency Numbers	Our AMA (1) believes that the Drug Enforcement Agency should refrain from divulging a physician's DEA number unless there is a valid reason for doing so; (2) believes that insurance companies and pharmaceutical companies should use a physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled substances are not involved; (3) will develop model legislation to restrict the use of the DEA number for monitoring the prescribing of controlled substances only; and (4) supports legislation or regulations to prevent insurance companies and other entities from using DEA registration numbers for identification of physicians.	Retain – This policy remains relevant.
H-175.986 Bounty Hunter Provision of the Health Insurance Portability and Accountability Act of 1996	The AMA will work toward amending the Health Insurance Portability and Accountability Act of 1996 by imposing civil monetary penalties for fraudulently and falsely reporting physician fraud or abuse.	Retain – This policy remains relevant.
H-265.998 Guidelines for Due Process	While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires: (1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her. (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing. (3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules. (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing. (5) The physician	Retain – This policy remains relevant.

Policy Number / Title	Text	Recommendation
	against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her. (6) The physician is entitled to the opportunity to present a defense to the charges against him or her. (7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome. (8) The hearing panel should render a decision based on the evidence produced at the hearing. (9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and validation of the completed remediation process. (10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible. (11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bear on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed. (12) In any hearing, the interest of patients and the public must be protected.	
H-270.958 Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid-Level Practitioners	1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities. 2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians	Retain – This policy remains relevant.

Policy Number / Title	Text	Recommendation
	(MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.	
H-270.960 Inappropriate Legislative Mandates of eGFR Calculations	Our AMA supports the position that (1) the estimated Glomerular Filtration Rate Calculation (eGFR) calculation, when appropriate and feasible, is a clinically useful calculation that should be promoted in the medical community in a scientific manner as a calculation that does NOT require state legislation or state law that would create an inflexible, politically-based mandate for the practice of medicine that, in general, can be deleterious to patient care; and (2) legislation mandating the eGFR calculation improperly and detrimentally prescribes medical decision-making to the extent that it deprives a physician of the ability to make appropriate, patient-specific clinical judgments regarding the performance of the calculation.	Retain – This policy remains relevant.
H-270.968 Preservation of Political Advocacy by Nonprofit Organizations	The AMA continues to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services.	Retain – This policy remains relevant.
H-315.987 Limiting Access to Medical Records	Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.	Retain – This policy remains relevant.
H-330.995 Amendments to the Medicare Civil Penalties Section of the Social Security Act	The AMA supports amendment of the Social Security Act to permit trial de novo for a physician who so requests when the sum of the penalties levied is greater than $10,000 and/or when a suspension from the Medicare program is applied.	Retain – This policy remains relevant. Section 813 of the Bipartisan Budget Act of 2015 raised criminal and civil monetary penalties for physicians who submit medical evidence in connection with disability claims.
H-370.968 Endorsement of the Uniform Anatomical Gift Act (2006)	Our AMA endorses the Uniform Anatomical Gift Act of 2006, and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA.	Retain – This policy remains relevant.
H-390.853 Protecting Patient Access to High Quality Imaging Services	Our AMA actively supports repeal or delay of the provision under Section 5102 of the Deficit Reduction Omnibus Reconciliation Act of 2005 that reduces the technical component payment (including the technical component of the	Retain – This policy remains relevant.

Policy Number / Title	Text	Recommendation
	global payment) for an imaging service under the physician payment schedule if it exceeds (without regard to geographic wage adjustment factor) the outpatient department payment schedule amount for the service established under the Medicare prospective payment system for hospital outpatient departments.	
H-400.989 Physician Negotiations	The AMA supports federal legislation that would allow the AMA and state medical associations, on behalf of physicians, to negotiate payment schedules on federal and state policies, respectively, impacting on physician reimbursement.	Retain – This policy remains relevant.
H-435.952 Savings Accounts for Extended Reporting Endorsement Policies and Other Liability Insurance Costs	Our AMA supports changes to the Internal Revenue Code to allow a pre-tax Extended Reporting Endorsement Savings Account whereby the amount of money contributed before taxes and interest on earnings from those monies be allowed to grow tax free until such time as an extended reporting endorsement must be purchased and that the balance of any remaining funds would return to the physician without IRS penalty and be subject to taxation at that time.	Retain – This policy remains relevant.
H-435.958 Immunity from Professional Liability Tort for Volunteer Services During State or National Emergencies	The policy of the AMA is to formulate and support federal legislation granting legal immunity, including medical liability immunity, for volunteer medical services arising from declared state or national emergencies.	Retain – This policy remains relevant and accords with AMA support of the Good Samaritan Health Professionals Act.
H-435.960 Physician Relief from Product Class Actions	Our AMA: (1) asks Congress to pass legislation which prevents naming the treating physician as a party to product liability lawsuits when the treating physician has used a Food and Drug Administration-approved drug or device; and (2) promotes the introduction of legislation which would exempt physicians who have properly prescribed usage of Food and Drug Administration-approved medications from liability in class action suits against pharmaceutical companies.	Retain – This policy remains relevant. Although H-435.948 addresses Supreme Court jurisprudence in 2008 and 2009 by seeking to grant physicians "at least the same level of protection as manufacturers," there is still value in retaining policy that advocates physicians be exempted from liability altogether.
H-435.976 Liability Protection for Medical Volunteers	It is the policy of the AMA to endorse the concept of liability protection for medical volunteer services and to promote legislative efforts to achieve that goal.	Retain – This policy remains relevant. Although there are more specific policies dealing with aspects of volunteer liability protection, there is value in retaining a general statement of principles in this regard.
D-035.992 Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation	Our AMA will: (1) work jointly with state attorneys general to identify and prosecute those individuals who misrepresent themselves as physicians to their patients and mislead program applicants as to their future scope of practice; (2) pursue all other appropriate legislative, regulatory and legal actions through the Scope of Practice Partnership, as well as actions within hospital staff organizations, to counter misrepresentation by nurse doctoral programs and their students and graduates, particularly in clinical settings; and (3) work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified either verbally, or by name badge or similar identifier, with regard to their professional licensure in order that patients are aware of the professional educational background of that person.	Retain – This policy remains relevant.
D-100.981 Security of DEA Numbers and National Provider Identifier Information	Our AMA will: (1) work with the Drug Enforcement Administration (DEA) and Congress to assure that DEA numbers are not readily available to the public for commercial or other purposes not essential for prescribing verification; (2) continue efforts to work with the Centers for Medicare and	Rescind – The directives in this policy have either been achieved or are included in other policies, H-100.972 and H-100.982.

Policy Number / Title	Text	Recommendation
	Medicaid Services regarding the security, dissemination and integrity of the National Provider Identifier (NPI); (3) report back to the House of Delegates at the 2006 Annual Meeting, and annually thereafter for five years, on the outcome of these efforts to assure that DEA numbers and the NPI are only available and used for their intended purposes; and (4) undertake a widespread campaign to inform physicians that the use of DEA numbers for purposes of identification other than for prescription of controlled substances is inappropriate and that this campaign be positioned to inform the various entities which inappropriately request DEA numbers.	
D-100.985 Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient	Our AMA will: (1) continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting; and (2) work with the Congress, the Food and Drug Administration, the Drug Enforcement Administration, and other federal agencies, the pharmaceutical industry, and other stakeholders to ensure that these illegal activities are minimized.	Retain – This policy is still relevant.
D-100.987 DEA Number	Our AMA will (1) make a renewed effort to stop the misuse of Drug Enforcement Administration (DEA) numbers by petitioning the US Department of Justice and/or any other appropriate federal agency to seek an immediate injunction or any other appropriate legal remedy to limit the use of DEA numbers to controlled substance prescriptions only; and (2) vigorously implement Policy H-100.972 regarding the appropriate use of DEA numbers.	Rescind – The directives in this policy are covered in other policies, including H-100.972 and H-100.982.
D-100.988 Tracking and Punishing Distributors of Counterfeit Pharmaceuticals	Our AMA will support the Food and Drug Administration's efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals.	Retain – This policy is still relevant.
D-100.994 Physician Prescribing Data and Use of DEA Activities	Our AMA will continue its legislative efforts to limit use of the DEA numbers to federal agencies authorized to enforce the laws regarding manufacture, distribution, and dispensing of controlled substances.	Rescind – The directives in this policy are covered in other policies, including H-100.972 and H-100.982.
D-120.995 Access of Physician Prescribing Patterns	Our AMA will: (1) study legally appropriate means to: (a) prevent drug companies from having access to physician prescribing patterns; (b) prevent pharmacies and third party payers from releasing this physician-specific information; (c) protect patients and physicians from the use of this prescribing pattern information by pharmaceutical companies; and (d) prevent the use of DEA numbers as pharmaceutical marketing tools; and (2) report its findings at the 2001 Annual Meeting.	Rescind – The directives in this policy are covered in other policies, including H-100.972 and H-100.982, and the report was presented as required.
D-130.970 Development of Bridge Income Strategies for Physicians Impacted by Officially Declared Disasters	Our AMA will evaluate strategies to create or support federal legislation and/or regulations which would provide bridge financial support to physicians following officially declared disasters to ensure an adequate supply of physicians to treat the population of the recovering areas.	Retain – This policy remains relevant.
D-185.993 Advocacy for Repeal of the Uniform Individual Accident and Sickness Policy Provision Law (UPPL)	Our AMA will support state and specialty medical societies and the public health associations in their efforts to secure repeal of laws and state insurance codes which allow for the denial of insurance payments for the treatment of injuries sustained as a consequence of the insured person being intoxicated due to alcohol or under the influence of narcotics.	Retain – This policy remains relevant.
D-190.977 Insurance Reimbursements	Our AMA will: (1) seek legislation requiring managed care companies and any third party carrier including Medicare to request a refund from physicians in the same time period they give physicians to file a claim in the contract; and (2) seek legislation that managed care companies and any third party carrier including Medicare in no case be allowed more than 180 days to request a refund from a physician.	Retain – This policy remains relevant. The newly finalized CMS overpayments rule creates a 6-year look-back period.
D-270.990 Diagnosis of Disease and Diagnostic Interpretation of Tests	Our AMA will pursue all appropriate legislative, regulatory and legal actions to counter expansions of the scope of work by PhD clinical lab scientists and other non-physician	Retain – This policy remains relevant.

Policy Number / Title	Text	Recommendation
Constitutes Practice of Medicine to be Performed by or Under the Supervision of Licensed Physicians	laboratory personnel to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine.	
D-305.972 Title VII Funding	Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of $300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.	Rescind – No new federal funds are required to maintain the Title VII Health Professions Student Loan programs. They are now funded with the interest from student/graduate repayment, creating a self-sustaining revolving fund. As such, these programs are exempt from Sequestration; however, cuts to the Health Resources and Services Administration (HRSA) may affect the administration of the loans.
D-435.987 Medical Courts	Our AMA will draft an alternative judicial model for addressing medical liability claims based on special medical courts that are composed of judges trained in medical standards that could render more accurate decisions regarding whether medical malpractice has actually occurred and, if so, render a judgment as to the amount of monetary damages to be awarded.	Rescind – This policy has been achieved by adoption of the AMA Principles for Health Courts, H-435.951.
D-460.977 NIH Public Access Policy	Our AMA will: (1) continue to work with publishing and professional organizations, and continue to work with Congress to prevent any changes to the current policy that requires public release of NIH research articles within 12 months of publication; and (2) continue to advocate that free content be accessed at the AMA's online journal web sites, rather than at a government site, to preserve our brand and to promote use of other AMA resources.	Retain – This policy remains relevant.

Appendix 2 - AMA Policies Superseding Policies Recommended for Rescission

D-100.981 Security of DEA Numbers and National Provider Identifier Information
Our AMA will: (1) work with the Drug Enforcement Administration (DEA) and Congress to assure that DEA numbers are not readily available to the public for commercial or other purposes not essential for prescribing verification; (2) continue efforts to work with the Centers for Medicare and Medicaid Services regarding the security, dissemination and integrity of the National Provider Identifier (NPI); (3) report back to the House of Delegates at the 2006 Annual Meeting, and annually thereafter for five years, on the outcome of these efforts to assure that DEA numbers and the NPI are only available and used for their intended purposes; and (4) undertake a widespread campaign to inform physicians that the use of DEA numbers for purposes of identification other than for prescription of controlled substances is inappropriate and that this campaign be positioned to inform the various entities which inappropriately request DEA numbers. (Res. 905, I-05; Reaffirmed, A-06)

H-100.972 Misuse of the DEA License Number
Our AMA: (1) affirms its opposition to use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe the substance; and will explore measures to discourage or eliminate the use of physicians' DEA license numbers as numerical identifiers in insurance processing and other data bases, either through legislation, regulation or accommodation with organizations which currently insist on collection of this sensitive data; (2) seeks to have its proposed legislation introduced, which would limit the use of DEA numbers to those federal and state entities that use the number to oversee and enforce the law regarding the manufacture, distribution, and dispensing of controlled substances; and (3) continues to advocate for the adoption of the AMA's Medical Education number as the unique identifier for physicians. (Res. 510, A-94; Reaffirmed by Rules & Credentials Cmt. A-96; Reaffirmed, A-97; Appended: Sub. Res. 207, I-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed, Sub. Res. 207 I-00; Reaffirmed, A-06).

H-100.982 Confidentiality of Drug Enforcement Agency Numbers
Our AMA (1) believes that the Drug Enforcement Agency should refrain from divulging a physician's DEA number unless there is a valid reason for doing so; (2) believes that insurance companies and pharmaceutical companies should use a

physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled substances are not involved; (3) will develop model legislation to restrict the use of the DEA number for monitoring the prescribing of controlled substances only; and (4) supports legislation or regulations to prevent insurance companies and other entities from using DEA registration numbers for identification of physicians. (Res. 123, I-89; Reaffirmed by Rules & Credentials Cmt. A-96; Reaffirmed, Sub. Res. 221, A-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed, A-99; Appended: Res. 701, I-03; Reaffirmed, A-06).

D-100.987 DEA Number
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D-100.994 Physician Prescribing Data and Use of DEA Activities
Our AMA will continue its legislative efforts to limit use of the DEA numbers to federal agencies authorized to enforce the laws regarding manufacture, distribution, and dispensing of controlled substances.

H-100.972 Misuse of the DEA License Number
Our AMA: (1) affirms its opposition to use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe the substance; and will explore measures to discourage or eliminate the use of physicians' DEA license numbers as numerical identifiers in insurance processing and other data bases, either through legislation, regulation or accommodation with organizations which currently insist on collection of this sensitive data; (2) seeks to have its proposed legislation introduced, which would limit the use of DEA numbers to those federal and state entities that use the number to oversee and enforce the law regarding the manufacture, distribution, and dispensing of controlled substances; and (3) continues to advocate for the adoption of the AMA's Medical Education number as the unique identifier for physicians. (Res. 510, A-94; Reaffirmed by Rules & Credentials Cmt. A-96; Reaffirmed, A-97; Appended: Sub. Res. 207, I-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed, Sub. Res. 207 I-00; Reaffirmed, A-06).

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D-120.995 Access of Physician Prescribing Patterns
Our AMA will: (1) study legally appropriate means to: (a) prevent drug companies from having access to physician prescribing patterns; (b) prevent pharmacies and third party payers from releasing this physician-specific information; (c) protect patients and

physicians from the use of this prescribing pattern information by pharmaceutical companies; and (d) prevent the use of DEA numbers as pharmaceutical marketing tools; and (2) report its findings at the 2001 Annual Meeting.

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D-435.987 Medical Courts
Our AMA will draft an alternative judicial model for addressing medical liability claims based on special medical courts that are composed of judges trained in medical standards that could render more accurate decisions regarding whether medical malpractice has actually occurred and, if so, render a judgment as to the amount of monetary damages to be awarded. (Res. 916, I-03; Reaffirmation A-06.)

H-435.951 AMA Principles for Health Courts
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 serving on a health court.
- 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.

I. Health Court Structure
Jurisdiction
- 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.

Trial Format
- 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.

Administrative Option
- 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.

Health Court Judges
Selection of Health Court Judges
- Health court judges should be appointed by a health court task force.
- 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.

Training for Health Court Judges
- 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.

III. Health Court Procedure
Threshold for Patient Compensation
- Negligence must be proven for a patient to recover in a health court proceeding.

Damages
- 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 (for punishment to prevent future bad behavior). The instructions should also distinguish the different burden of proof needed for punitive damages.
- Future damages should be paid on a periodic basis as authorized by a health court.

Other Procedural Issues
- 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.

IV. Medical Error Reporting
Medical Error Reporting
- 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.

V. Experts
Court Appointed Medical Experts
- 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.
- 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.

Party Expert Witnesses
- 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.

VI. Review and Sunset
Review
- 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.

Sunset
- 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.

7. REDEFINING THE AMA'S POSITION ON ACA AND HEALTH CARE REFORM – UPDATE

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 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 Report 6-I-13 accomplished the original intent of the policy. This report serves as an update on the issues discussed in that and subsequent reports.

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR

The Sustainable Growth Rate (SGR) formula was repealed by the enactment of the "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA) on April 16, 2015. Two payment alternatives were created to replace the SGR, the Merit-Based Incentive Payment System (MIPS) and an option to participate through Alternative Payment Models (APMs). The Centers for Medicare & Medicaid Services (CMS) solicited comments on the design and implementation of the component parts of the MACRA as part of the Calendar Year 2016 Physician Fee Schedule Proposed Rule, and subsequently, though a Request for Information published on October 1, 2015. In addition to numerous meetings with CMS officials charged with the implementation of MACRA, our AMA responded to these requests by providing extensive guidance[1,2] on the appropriate implementation of both the MIPS and APMs.

Our AMA has also established a Task Force of State and Specialty Society CEOs to provide guidance on efforts surrounding MACRA implementation. Under the leadership of the Task Force, a letter signed by more than 100 state and specialty societies was sent to CMS Acting Administrator Andrew Slavitt on November 16, 2015, outlining 10 consensus principles for the implementation of MIPS and APMs.[3] In brief, these principles are: Support delivery system improvements; Avoid administrative and cost burdens for patients; Reduce administrative burdens for physicians; Improve current quality and reporting systems; Recognize patient diversity; Provide choice of payment models; Be equitable; Be relevant and actionable; Provide stability and Resources; and Be transparent. These efforts were further enhanced by the establishment of separate workgroups of state and specialty society professional staff focused on MIPS and APM implementation.

Additionally, the AMA has published "A Guide to Physician-Focused Payment Models" and actively engaged medical specialty societies on the development of condition specific alternative payment models.

Each of these efforts has been undertaken with the goal of maximizing physician leadership and input into the development and implementation of MIPS and APMs.

PAY-FOR-PERFORMANCE

Inherent in the implementation of the MIPS program is the opportunity to enact important reforms to current pay-for-performance programs. Our AMA commented extensively on the need to reset these programs in communications to CMS referenced above. Central to these comments is the concept that the MIPS program should be "truly value-based and meaningful to the majority of physicians and their patients." Issues raised include: the timeliness of the data used, the "one-size fits all" nature of PQRS requirements, flawed methodologies, and insufficient measures. Our AMA has called for more flexibility and significant methodological improvements to adjust for differences in specialty, site of service, type of practice, and patient mix.

On March 1, 2016, our AMA wrote Acting Administrator Slavitt regarding CMS' Quality Measure Development Plan, and called on CMS to:

- Re-think the design of quality programs for Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) to take into consideration the varying specialties within medicine. We encourage CMS to take a new view that uses measurement more as a guide to address broad problems;
- Provide more timely data and feedback to physicians so programs are based on intrinsic motivation rather than narrowly focusing on penalties and rewards; and
- Develop measures in a transparent process through physician-led organizations to ensure that the measures are meaningful to users, uphold national standards, and harmonize with clinical data registries.

Also on March 1, 2016, in comments on CMS' Request for Information Regarding Episode Groups, our AMA provided extensive comments calling for:

- Initial efforts to focus on validation of the measures rather than the volume of the costs that are covered and for placing a priority on a small set of measures that were developed for use in the physician office and have the support of the specialties that provide key services within the episode;
- Ensuring greater involvement of physicians and professional societies that represent them in future efforts to design, evaluate, and implement episode groups; and

- Looking to specialty societies for assistance in assessing the impact on patient access of the proposed episode groups.

Comments also provided suggestions for additional Episode Groups to include recommendations from the medical specialties, state Medicaid programs, Qualified Clinical Data Registries, and specialties' alternative payment model submissions to CMS.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

As noted in Board of Trustees Report 4-I-15, Rep. Phil Roe, MD (R-TN) has introduced the "Protecting Seniors' Access to Medicare Act of 2015" which would repeal the Independent Payment Advisory Board established by the Affordable Care Act. On June 23, 2015, the House of Representatives adopted the bill by a vote of 244-154. The AMA supported passage of the legislation. However, to offset the cost of the bill, provisions were added by the Rules Committee prior to floor consideration that made cuts to the ACA's Prevention and Public Health Fund, which are explicitly opposed by AMA House of Delegates Policy. AMA communications in support of the bill noted this issue and urged efforts to identify alternative offsets as the bill moved forward. The US Senate has yet to act.

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

As previously reported in Board of Trustees Report 4-I-15, Representative Tom Price, MD (R-GA) and Senator Lisa Murkowski (R-AK) have reintroduced the "Medicare Patient Empowerment Act" (H.R. 1650/S. 1849) with the support of our AMA. No additional action has occurred on these bills to date.

STEPS TO LOWER HEALTH CARE COSTS

The AMA continues to seek opportunities to advance policies that will lower health care costs. Central to these efforts is the AMA's work on Improving Health Outcomes. Efforts to achieve Medicare coverage of diabetes prevention programs continue through legislation such as the Medicare Diabetes Prevention Act (S. 1131/H.R. 2102) and directly through the Medicare coverage determination process.

Over a period of months, our AMA has consulted with the Senate Finance Committee Chronic Care Working Group, suggesting numerous initiatives for the committee's consideration that would lead to lower health care spending by addressing chronic health care needs.[4] On December 18, 2015, the committee released its final options paper[5] after having met with hundreds of organizations. We were pleased the recommendations related to diabetes prevention programs were included, as were numerous other policies with broad bipartisan support. Our AMA will continue to work closely with the committee as they translate these recommendations into legislation.

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

Legislation repealing the non-physician provider non-discrimination provisions of the ACA has not been introduced in the current Congress to date.

CONCLUSION

AMA Policy D-165.938 calls for updates at each meeting of the HOD on a number of specific policies related to the ACA. Our AMA continues to pursue these issues. Other key advocacy issues will continue to be addressed in the annual Advocacy report at each Interim Meeting of the House.

REFERENCES

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2 https://download.ama-assn.org/resources/doc/washington/x-pub/macra-letter-17nov2015.pdf
3 https://download.ama-assn.org/resources/doc/washington/x-pub/macra-sign-on-letter-16nov2015.pdf
4 https://download.ama-assn.org/resources/doc/washington/x-pub/medicare-chronic-care-letter-22june2015.pdf
5 http://www.finance.senate.gov/release/hatch-wyden-isakson-warner-release-chronic-care-options-paper

8. AMA PERFORMANCE, ACTIVITIES AND STATUS IN 2015

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy G-605.050 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 AMA continued work in 2015 toward shaping–and helping physicians navigate–new care delivery and payment models in ways that promote professional satisfaction and practice sustainability.

This work was greatly enhanced by the repeal of the Sustainable Growth Rate (SGR). After more than a decade of determined advocacy efforts on Capitol Hill, the AMA, in representing the interests of physicians, attained a top legislative goal in its role as a driving force in repealing the untenable SGR formula. This success, accomplished in collaboration with the Federation, eliminated a budget gimmick that threatened the financial viability of physician practices, hindered patient access to care, and thwarted payment and delivery innovation. SGR's 2015 fall has opened the door to building a stable and sustainable Medicare program that our nation's patients and physicians need and deserve.

MACRA Implementation: With repeal of the SGR complete, the AMA turned to implementation of the HR2 Medicare Access and CHIP Reauthorization Act (MACRA), which was the law that repealed the SGR and created new payment and delivery options for physicians. Along with the Federation, we continue to work with policymakers to ensure MACRA is implemented properly for physicians and patients.

Reset Meaningful Use: The AMA amplified its work with lawmakers and regulators to reset the Meaningful Use (MU) program in 2015. The "Break the Red Tape" campaign (breaktheredtape.org) calls attention to the inadequacies within the current MU program and the detrimental effects that it has on physician practices and patient care. In response to the campaign, CMS officials are offering physicians extended MU hardship exemptions and indicated intent to further reduce MU regulatory burdens and provide greater flexibility as part of MACRA implementation.

In collaboration with RAND Health, AMA released a new report examining the effect that new payment models are having on physician practices. The study was a key informant to subsequent work defining the scope of resources to be released by the AMA in 2016 to help physicians assess impact of new payment models on individual physician practices based on their practice type, specialty, patient population, payer mix and region.

The STEPS Forward™ practice transformation website launched in June 2015, and by year end offered 27 practice improvement modules for physicians and their staff. More than 10,000 unique users completed an online module or attended an in-person event focused on practice transformation. An innovation challenge was conducted in partnership with Medical Group Management Association (MGMA) to identify physician/member-generated content. Awards totaling $50,000 were presented in October and work began immediately to translate the ideas into STEPS Forward modules.

In September 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the AMA a Transforming Clinical Practices Initiative grant. Under this grant, AMA will provide technical assistance to practices as part of an ambitious, multi-year, national program to help deliver better care and result in better health outcomes at lower cost for Medicare, Medicaid and Children's Health Insurance Program enrollees.

The AMA continued to engage Electronic Health Record (EHR) and digital health vendors to incorporate needed changes in product design, training, implementation and interoperability. This included an AMA-hosted usability workshop in conjunction with the Electronic Health Record Vendor Association (EHRA) to promote better engagement between vendors and physicians. Other activities included a commissioned survey exploring the concerns physicians have with the current state of EHRs, which culminated in a co-branded report with American EHR and co-development with the Medstar Research Institute of an advanced methodology and EHR usability scorecard, which compares vendor design and testing processes to industry best practices.

To address physicians' challenges in working within larger health systems, the AMA worked with the American Hospital Association to produce a report entitled, "Integrated Leadership for Hospitals and Health Systems: Principles for Success."

Improving Health Outcomes

In 2015, AMA focused on empowering physicians and health teams to partner with patients in modifying behavior and achieving better health through prevention. The AMA joined together with the YMCA of the USA to address the growing burden of type 2 diabetes. The AMA worked closely with state medical societies and local YMCA branches across eight states to engage more than 500 physicians in identifying people at high risk of diabetes and referring them to evidence-based lifestyle change programs.

The AMA together with the Centers for Disease Control and Prevention (CDC) launched Prevent Diabetes STAT/Screen/Test/Act Today™ as a call to action to increase awareness of prediabetes and enrollment of at-risk individuals in lifestyle change programs that are part of the CDC's National Diabetes Prevention Program. Individuals, physicians, care teams, health plans and employers can access materials at preventdiabetesstat.org.

In partnership with the American Diabetes Association, the CDC and the Ad Council, the AMA developed a public awareness campaign to educate the public about pre-diabetes and encourage people to be screened. Television, radio and print public service announcements were created in 2015 and launched in January 2016 to achieve this goal and to direct the public to resources at www.doihaveprediabetes.org.

Our AMA crafted educational materials to support clinical care teams in their efforts to prevent type 2 diabetes and improve blood pressure control. Training materials hosted on AMA websites were downloaded more than 10,000 times and more than 500 clinical care team members across four states received training on the AMA's evidence-based protocols for blood pressure measurement.

Hundreds of medical students and residents from across the nation participated in workshops and seminars organized by the AMA to highlight different aspects of the AMA's work on preventing type 2 diabetes and improving blood pressure control.

Accelerating Change in Medical Education (ACE)

In 2015, AMA added 21 medical schools to the 11 schools that founded the ACE Consortium in 2013. Together, these 32 schools affect the education of 19,000 students. They are working to identify and widely share the best models for educational change to ensure future physicians are prepared for a lifetime of learning, to lead a team of professionals in delivering care, and to explore innovative ways to care for patients, populations and communities in the evolving health care system.

The AMA hosted the ChangeMedEd2015 conference to spread Consortium innovations beyond member schools. ChangeMedEd2015 brought together 350 of the world's most notable leaders and innovators in medical education from more than 120 organizations to generate new ideas and transform the way physicians are trained.

The Medical Education Innovation Challenge invited medical students to address the question, "How would you turn medical education on its head?" A total of 146 teams, each led by an MD or DO student, submitted written proposals and videos outlining how they would transform medical education. Teams competed for cash prizes and the opportunity to share their ideas with medical education leaders.

Based on a previous Council on Medical Education forum in which stakeholders from diverse organizations discussed the challenges faced by physicians reentering clinical practice, the AMA collaborated with the Physician Reentry into the Workforce Project to create an issue brief, *Physician Reentry Themes and Opportunities.* The issue brief includes eight themes identified during the forum and is available to the public at PhysicianReentry.org.

Authors from the Council on Medical Education, Academic Physicians Section, AMA staff, Accreditation Council for Graduate Medical Education, and Foundation for Advancement of International Medical Education and Research collaborated on an article, published in *Medical Education* in November, on concerns and challenges with the implementation of competency-based medical education.

The Liaison Committee on Medical Education approved a revision to accreditation standards to eliminate duplication in the information that schools need to supply during a review. Effective July 2015, 132 standards were consolidated into 12 standards with 95 elements. Schools and survey teams received orientation and training, and all schools are now being reviewed using the new standards.

Advocacy on behalf of the Profession

Health Insurer Mergers: In 2015, the AMA aggressively opposed two separate merger attempts involving four of the five largest national health insurers. The AMA has argued before Congress, the Department of Justice and state insurance departments that the mergers would further impair access, affordability and innovation in markets for health insurance shown by AMA research to be highly concentrated.

ICD-10: After several delays, it was apparent that the transition to ICD-10 would occur in 2015. The AMA worked with federal policymakers to facilitate as smooth a transition as possible for physician practices. CMS agreed to provide physicians with flexibility on the needed specificity for codes and also established an ombudsman to handle transition problems.

Opioid Abuse: The AMA launched the Task Force to Reduce Opioid Abuse and gained nationwide attention for its recommendations urging physicians to use prescription drug monitoring programs and take enhanced education on effective, evidence-based prescribing. www.ama-assn.org/go/endopioidabuse.

Network Adequacy: The AMA worked with state and federal policymakers to make certain that insurer physician networks have meaningful, active and continuous oversight; are evaluated with measurable standards; and provide transparency in network selection standards/provider directories.

Publishing

On the publishing and clinical front, for the first time in 12 years, JAMA® the Journal of the American Medical Association added a new title, the *Journal of Oncology*, to its lineup of highly respected resources and timely, original, scientific and educational content. Additionally, Virtual Mentor, which publishes monthly content related to ethical topics in health and medicine was renamed, "AMA Journal of Ethics," and was transitioned to a peer-reviewed format, allowing consideration of unsolicited manuscripts. This represented a considerable milestone in the academic publishing community.

Innovation

The AMA partnered with MATTER, an innovation incubator located in Chicago, to give physicians opportunities to improve health care by providing input to entrepreneurs who are developing products and services. The AMA Interaction Studio**,** which is an extension of MATTER, further connects physicians and health tech entrepreneurs—both live and virtually—to a nationwide innovation hub.

The AMA was also a founding partner of Health 2047 Inc. Based in San Francisco, this exciting collaborative advances the AMA's goal of improving the health of the nation through the discovery and development of new solutions for physicians and their patients.

The AMA-convened Physician Consortium for Performance Improvement became the PCPI Foundation® (PCPI®), an independent 501(c)(3) not for profit multi-stakeholder organization. The PCPI is now welcoming new member

organizations from across the health care environment, representing specialty medical societies, other clinicians, patients and consumers, payers, health plans, health systems, licensing bodies, (ex-officio) government agencies and others. Two AMA trustees serve on the inaugural PCPI board of directors.

Communicating with physicians

Through thousands of surveys and one-on-one interviews about practice needs and physicians' personal challenges, throughout 2015 AMA gleaned insights that are adding value to the content and approach we're taking in the creation and delivery of products, services and messaging.

AMA surpassed one million followers on social media through Facebook, Twitter, LinkedIn and Google Plus, and 1.5 million views of *AMA Wire*®. We are now in touch with a bigger audience than ever, sharing opinions and establishing an important dialogue with our core stakeholders– medical students, residents and physicians.

Well ahead of the 2016 re-launch of the AMA website, we radically overhauled the AMA's critical content covering important subjects across our strategic focus. We also re-engineered our targeted audience pages, to ensure our three core audiences can easily find information relevant to their unique needs.

EVP Compensation

During 2015, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $974,187 in salary and $886,799 in incentive compensation. Other taxable amounts per the contract were paid as follows: $14,478 for life insurance, $7,620 for executive life insurance, $2,500 for health club fees and $2,400 for parking. An $81,000 contribution to a deferred compensation account was made by the AMA. This will not be taxable until vested pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the AMA 2015 Annual Report.

9. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2015 THROUGH FEBRUARY 2016

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2015 through February 2016 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. From March 2015 through February 2016 the CDC released 10 MMWRs related to tobacco use. Among the topics were youth and adult smoking rates, trends in quit attempts and e-cigarette advertising.

2015: www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2015/index.htm

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

Smoking Rates and Trends

During 2015-2016, there were four MMWR reports that focused on smoking rates and trends in youth and adults. These trend 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.

The October 2, 2015 MMWR released data from the National Youth Tobacco Survey (NYTS) which is a cross-sectional, school-based questionnaire administered to US middle school (grades 6–8) and high school (grades 9–12) students. The report focused on current tobacco use and frequency of use among middle and high school students. In 2014, an estimated 4.6 million middle and high school students were current users of any tobacco product (e.g., ≥ 1 cigarette/day during the preceding 30 days), of whom an estimated 2.2 million were current users of two or more types of tobacco products. Symptoms of nicotine dependence are increased for multiple tobacco product users compared with single-product users. Current tobacco use was assessed for nine products: cigarettes, cigars, smokeless tobacco (defined as chewing tobacco, snuff, or dip), e-cigarettes, hookahs, tobacco pipes, snus, dissolvable tobacco and bidis. Frequency of use was asked exclusively for four products: cigarettes, cigars, smokeless tobacco, and e-cigarettes. Among middle and high school students who used at least one of these four products, an estimated 480,000 middle school and high school students smoked cigarettes, 390,000 used smokeless tobacco, 340,000 used e-cigarettes, and 170,000 smoked cigars on ≥ 20 of the preceding 30 days.

The November 13, 2015 MMWR assessed progress toward achieving the Healthy People 2020 objective of reducing the percentage of US adults who smoke cigarettes to ≤ 12.0%. CDC assessed data from the 2014 National Health Interview Survey. The percentage of US adults who smoke cigarettes declined from 20.9% in 2005 to 16.8% in 2014.

Adults aged 18–24 years experienced the greatest decrease in cigarette smoking prevalence. However, recent reports suggest that use of non-cigarette tobacco products, including e-cigarettes and hookahs, is common among youth and young adults (April 17, 2015 MMWR Tobacco Use Among Middle and High School Students — United States, 2011–2014). The observed decline in cigarette use in the 18-24 year old age group could be associated with an increase in the use of emerging tobacco products such as e-cigarettes by high school students. Further research in this area is ongoing.

Observed disparities in smoking prevalence remained among persons with disabilities and persons with limited access to smoking cessation treatment. These disparities underscore the importance of enhanced implementation of proven strategies to prevent and reduce tobacco use such as cessation coverage, targeted media campaigns, and taxation and access policies.

Quit Attempts Decrease in Older Smokers

The October 22, 2015 MMWR looked at trends in quit attempts among adult cigarette smokers in the US from 2001 to 2013. During 2001–2010, the proportion of adult cigarette smokers who had made a quit attempt in the past year increased, and from 2011–2013, a majority of smokers in all age groups tried to quit in almost all states. In 2013, approximately two-thirds of smokers had made a quit attempt in the past year although the proportion of smokers who attempted to quit decreased with increasing age. The median proportion who made a quit attempt was 73% in the 18-24 age group and 56% in those over 65. The report does not discuss why attempts decrease with age but it could be related to the effect that certain strategies such as increased taxes have on younger smokers. Quit attempt rates varied, with higher rates in those states that invested in surveillance and evaluation, and implemented evidence-based interventions such as increasing taxes on tobacco products, implementing smoke-free laws, improving health insurance coverage of cessation services, and ensuring that treating tobacco dependence is integrated into routine clinical care for everyone.

Youth Exposed to E-Cigarette Advertising Due to Lack of Regulations

There has been an increase in use of e-cigarettes among youth since 2011, when it was first being tracked by inclusion in the NYTS. The CDC analyzed data from the 2014 survey, which included advertising exposure in addition to use. The January 8, 2016 MMWR found that almost 70% of middle and high school students were exposed to ads from at least one source. Retail stores were cited as the number one source by 54% of the respondents followed by the Internet at 40% and TV and movies at 37%. Advertising for cigarettes has been shown to prompt initiation and maintain tobacco use among youth. A study on the effect of e-cigarette advertising conducted by Farrelly, et al. in the November 2015 *American Journal of Preventive Medicine* found a similar link between intent to use and exposure to ads. Youth exposed to the TV ads were 54% more likely to say they would try

an e-cigarette soon and 43% more likely to say they would try an e-cigarette within the next year compared with youth who were not exposed to the ads. The study also determined that youth who saw the ads were more likely to agree that e-cigarettes can be used in places where smoking is not allowed. This perception is perhaps the most troubling aspect of the unregulated e-cigarette industry. These products are contributing to the confusion about the negative health effects of these products and the acceptance of the industry's strategy to portray these as safer or healthier alternatives to cigarettes.

AMA TOBACCO CONTROL ACTIVTIES

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. Activities of this partnership include support for eliminating the use of smokeless tobacco at baseball venues. In September 2015, the Boston City Council voted unanimously to ban smokeless tobacco and other tobacco products at all professional and amateur sports venues including Fenway Park. The ban takes effect on April 1, 2016. In January 2016, the Los Angeles City Council voted unanimously to approve an ordinance outlawing the use of smokeless tobacco products at all baseball fields and other athletic venues in the city of Los Angeles. The new ordinance will be in effect before the 2016 baseball season gets underway at Dodger Stadium, where the ban covers players, team staff, personnel and fans.

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 January 2016. 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.

AMA Joins Public Health Advocates on National Panel

Omar Hasan, MBBS, Vice President of Improving Health Outcomes at the AMA, was invited to present at the American Public Health Association Annual Meeting and Exposition that was held in Chicago, October 2015. Dr. Hasan was part of a panel–*New Threats to Youth Tobacco Prevention*: *Bringing Together Partners from State, Sections and National Groups.* Dr. Hasan described the history of physician engagement in the tobacco control environment. He assessed the effect of e-cigarettes on smoking cessation for clinical practice and explained the need for physicians to engage in public health advocacy outside the medical practice.

AMA Continued its Support for FDA Scientific Advisory Committee

In March 2015, the AMA joined with public health organizations and medical groups on an *amici curiae* brief in support of the US Food and Drug Administration in a suit against it by Lorillard that resulted in highly qualified individuals being removed from the FDA Products Scientific Advisory Committee. The brief was filed to support an appeal from the FDA. Oral arguments have not been scheduled. This is one of several lawsuits filed by tobacco companies to weaken the intent of the provisions of the Family Smoking Prevention and Tobacco Control Act of 2009. The AMA has joined in filing similar amicus briefs.

Youth Surveillance Survey Key to Reducing Youth Tobacco Use

The AMA demonstrated its ongoing support for the NYTS by submitting a letter of support 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.

AMA Calls for Updated FAQ on Comprehensive Cessation Benefit

The Affordable Care Act required that all non-grandfathered private health insurance plans cover preventive services given an 'A' or 'B' rating by the US Preventive Services Task Force (USPSTF) which includes tobacco cessation interventions. In May 2014 the US Departments of HHS, Labor and Treasury issued an ACA Implementation FAQ that addressed the USPSTF tobacco cessation recommendations. On September 21, 2015, the USPSTF released an updated recommendation statement "Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions." The statement includes the following recommendation:

The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration-approved pharmacotherapy for cessation to adults who use tobacco. (A recommendation)

This updated recommendation summary statement makes it clear that the USPSTF considers tobacco cessation treatment as a preventive service that includes behavioral interventions (counseling) and pharmacotherapy interventions (medications). Given this new recommendation, the AMA joined public health organizations and other medical groups asking Secretary Burwell, US Department of Health & Human Services, Secretary Perez, US Department of Labor, and Secretary Lew, US Department of the Treasury to issue an updated Frequently Asked Questions document to reflect this updated USPSTF recommendation.

10. ELECTRONIC HEALTH RECORDS AND MEANINGFUL USE (RESOLUTION 224-A-15), PARTIAL CREDIT FOR ELIGIBLE PROFESSIONALS (RESOLUTION 227-A-15) AND REPEAL COMPULSORY ELECTRONIC HEALTH RECORDS (RESOLUTION 228-A-15)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-478.971

At the 2015 Annual Meeting, the House of Delegates (HOD) referred Substitute Resolution 224-A-15, "Electronic Medical Records and Meaningful Use" for report back at the 2016 Annual Meeting. This resolution was a consolidation of Resolutions 224-A-15, "Electronic Medical Records Vendor Accountability," introduced by Ohio State Medical Association, 227-A-15, "Partial Credit for Eligible Professionals for Accomplishing Meaningful Use Guidelines," introduced by Michigan State Medical Association and 228-A-15, "Repeal Compulsory Electronic Health Records," introduced by Texas Medical Association, which outlined various reforms for electronic health records (EHRs) and the Meaningful Use (MU) program. Substitute Resolution 224 asked that:

Our American Medical Association reaffirm policies D-478.982, H-478.991, and D-478.994;

Our AMA work with the Centers for Medicare & Medicaid Services and other relevant stakeholders to allow for partial credit for the eligible professionals accomplishing one or more objectives in the meaningful use program;

Our AMA engage with electronic health record vendors to develop and provide mitigation strategies and continuity training solutions to reduce the negative effects of system downtime and other technology disruptions;

Our AMA seek to mitigate the expense and loss of productivity caused by technology failures by advocating for hardship exemptions from the Meaningful Use program for eligible professionals who experience these problems; and

Our AMA develop model language to be included in EHR vendor contracts with eligible professionals that protects the eligible professional in the event of downtime due to vendor error and other technology problems.

This report outlines ongoing AMA advocacy on EHRs and the MU program as well as highlights AMA policy related to these issues. It also provides context regarding the current legislative and regulatory environment and how this may impact possible reforms to the program and EHRs.

BACKGROUND ON MEANINGFUL USE AND ELECTRONIC HEALTH RECORDS

In February 2009, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act as part of an economic stimulus package known as the American Recovery and Reinvestment Act. Congress enacted this provision to expand the adoption of EHRs—a goal originally set in 2004 by President George W. Bush in his State of the Union address. The HITECH law initially provides incentives followed by penalties to spur the adoption of EHRs 10 years from enactment.[1] To ensure that EHRs would be effective, incentives go to providers who demonstrate "meaningful use" of the technologies. This term is broadly defined in the law to require three components: 1) electronic prescribing; 2) health information exchange; and 3) quality reporting, leaving most of the details to the Centers for Medicare & Medicaid Services (CMS) to define later. The law also requires that EHR systems be certified as functional, secure, and technically sound. These criteria too were left for regulators to flesh out.[2]

Two agencies are primarily responsible for the implementation of the MU program: CMS, which outlines the measures providers must meet to be meaningful users of the technology, and the Office of the National Coordinator for Health Information Technology (ONC), which defines the technical requirements for EHRs. CMS' regulations went above and beyond the HITECH Act's statutory requirements, creating a program with three progressively onerous stages. Simultaneously, ONC's certification process created detailed requirements for EHR vendors that mainly focused on ensuring products could perform the MU requirements, rather than testing for usability, security, and interoperability.

To date, the MU program has faced significant challenges and setbacks. While approximately 80 percent of physicians have adopted EHRs,[3] many are still unable to meet the complex program requirements. In 2015, over half of eligible providers received an MU penalty.[4] In 2016, the program has seen little improvement, with roughly two out of five physicians failing to meet CMS' requirements.[5] In addition, physicians have experienced significant delays in obtaining updated EHR software from vendors, faced barriers to data exchange, and are struggling with unusable products.[6]

ONGOING AMA ADVOCACY

Our AMA has engaged in extensive advocacy to improve the MU program and EHRs, working with all levels of Congress, the Administration, and relevant stakeholders to secure changes. In addition to submitting extensive comments on each stage of the MU program and the certification criteria for EHRs, our AMA has provided testimony, helped introduce federal legislation, created practice tools, established EHR usability priorities and comparison guides, as well as many other efforts related to this program. This advocacy has led to numerous improvements, including extensions of the amount of time physicians could remain in one program stage before progressing to a more burdensome stage, additional hardship exemptions that allow physicians to avoid a financial penalty, greater transparency in the certification and cost of EHRs, shorter reporting periods for certain program years, and significant program modifications that lowered the number of requirements and thresholds for MU measures.

Substitute Resolution 224-A-15 specifically sought to improve the MU program through additional avenues, by allowing for partial credit, seeking additional hardship exceptions, and mitigating problems related to EHR downtime and technology failures. Those specific program changes are discussed in more detail below.

Partial Credit/Pass-Fail Program Design

Unlike other quality reporting programs, eligible professionals must achieve 100 percent of MU measures to avoid a financial penalty. The MU penalty is also not proportional, meaning that a physician who performs 99 percent of the program requirements receives the same penalty as a physician who met zero percent of the program requirements.

Our AMA has long advocated that this pass-fail design is unfair and should be changed to allow proportionality or partial credit. In particular, our AMA has supported many different options that would allow flexibility, including

creating different thresholds for what constitutes passing versus failing the program (for example, meeting 75 percent of measures would earn an incentive, while less than 50 percent performance would earn a penalty), creating scaled penalties that are proportional to performance, and allowing physicians to forego certain measures based on their specialty or patient population. Our AMA also endorsed federal legislation, the "Flex-IT 2 Act" (H.R. 3309), that would require CMS to implement MU incentives and penalties in a linear manner, providing credit if a participant is a partial meaningful user and considering differences among professionals in determining which objectives must be met.[7]

In April 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[8] This new law will consolidate the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), and MU programs into one quality reporting system in 2019, creating a new Merit-Based Incentive Payment System (MIPS). The new law determines a physician's performance based on a composite score: PQRS at 30 percent; VBM at 30 percent; MU at 25 percent; and clinical practice improvement activities (as of yet undefined) at 15 percent. Given this new structure, CMS has signaled that the new law will allow the agency to move away from the pass-fail approach and allow flexibility in the MU program to customize health IT to individual practice needs.[9]

Hardship Exceptions

The current MU program allows physicians to apply for hardship exceptions and avoid MU penalties if specific circumstances are met. These exceptions are typically valid for only one year and require the physician to fill out an application. Eligible professionals can apply for hardship exceptions in the following categories:

- Lack of Infrastructure: Eligible professionals must demonstrate that they are in an area without sufficient Internet access or face insurmountable barriers to obtaining infrastructure;
- Extreme and Uncontrollable Circumstances: An example includes a natural disaster;
- EHR Vendor Issues: The EHR vendor was unable to obtain certification or the eligible professional switched vendors;
- Patient Interaction: Lack of face-to-face or telemedicine interaction with patients or lack of follow-up need with patients; and
- Practice at Multiple Locations: Lack of control over availability of certified EHR technology (CEHRT) for more than 50 percent of patient encounters.[10]

Substitute Resolution 224 sought an additional hardship category related to technology failures. CMS, however, clarified in its final MU Stage 3 rule that it intends for these circumstances to be included in the existing hardship categories. Specifically, CMS noted that:

> Providers may already apply for a hardship exception under the extreme and uncontrollable circumstances category if they experience issues with a vendor product, including issues related to upgrades and transitions from one product to another…Finally, we believe that the existing categories are broad and comprehensive enough to cover many different circumstances where meeting the program requirements would be a significant hardship due to circumstances outside the control of the provider and related to their particular practice or organization.[11]

In addition, physicians have successfully used the EHR vendor category to apply for and receive exceptions when they experienced technology delays and other product problems. Accordingly, the technology concerns described in Substitute Resolution 224 are already covered by the existing MU hardship process.

System Downtime and other Technology Disruptions

Substitute Resolution 224 also sought to mitigate disruptions that occur due to EHR system downtime and other technology failures. Occasional temporary unavailability of EHRs is inevitable due to failures of software and hardware, required system upgrades, power outages, and natural disasters. Health IT trade press, however, has reported several significant cases where institutions experienced outages for several days or other glitches that have prohibited access to electronically-stored patient information.[12] These outages not only disrupt workflow but also can lead to serious patient safety issues.

Differences in the deployment of EHR systems can also play a role in how physicians experience unscheduled system downtime. Many early EHR systems required extensive network infrastructure, large data centers, and dedicated staff to maintain. Due to this expense, typically only large medical centers could implement first generation EHRs. Within the past 10 to 15 years technology has progressed to a point where complex software applications, like EHRs, can be run on off-the-shelf servers or personal computers (PC) and be supported by non-technical office staff. Yet, even with such technological advancements, the combination of hardware, software, and environmental conditions can result in system failures.

Many physician practices are located in offices that were not designed to accommodate the demands of EHR data centers. Most office space does not support dedicated air-conditioning, backup power, or reinforced/secure doors into the server room. Data back-up or long-term record retention policies can also require spare equipment and additional facilities in the event the main EHR system is damaged by human error, theft, or natural disasters. Additionally, in an attempt to reduce costs, many practices run multiple applications on the same server. In the event of a system disruption, multiple applications—like the EHR and practice management system—could be affected.

The potential impact of EHR unavailability also increases as systems are deployed across multiple facilities within a health care system. For example, a problem at one location may require that a system that is connected to the impacted location be shut down. Viruses and other technology threats are also more likely to occur as the number of connections to other systems and online tools increases. This problem is likely to only get worse as more information is stored, shared, and transmitted online.

Co-hosted and Software-as-a-Service Models

Until recently, locally-hosted or "client-server" EHRs were the only choice for physicians. Now, however, physicians interested in purchasing (or replacing) EHRs are no longer required to purchase and manage their own servers. There are a wide range of new and evolving system models, but two stand out for most physician practice needs. Together, co-hosted and Software-as-a-Service (SaaS) models account for the majority of cloud-hosted EHR systems. These Internet accessible, or cloud-based, systems are rapidly gaining popularity as physicians become increasingly comfortable with the cloud as a delivery method for their EHRs. According to a recent Black Book survey, 83 percent of the respondents identified cloud-based EHRs as the biggest trend in physician technology.[13]

Both co-hosted and SaaS-based EHRs provide the added benefits of not needing to purchase expensive hardware upfront, little to no maintenance, a reduced risk of data breaches, and increased business continuity protection. In a co-hosted environment, a physician still purchases the EHR software, but the server hardware and maintenance is offsite and managed by a third party. Many organizations offer co-hosting services, including Amazon, Google, and some EHR vendors. In a SaaS model, both the software and hardware are completely managed by the EHR vendor. A cloud-based EHR system delivered through SaaS can be securely accessed via almost any device with a Web browser and Internet connectivity. Physicians typically subscribe to the service for a fixed monthly fee.

Cloud-hosted systems are, however, not without risk. All hosting facilities have multiple paths to the Internet and incorporate other redundant systems to ensure a high-level of uptime. Typically, the greatest point of failure is the medical practice's Internet connection. As with all cloud-based hosting models, accessing an online EHR system requires a stable, high-speed connection to the Internet. Most offices have access to at least one high-speed Internet connection (e.g., cable modem, T1, Metro Ethernet), but even these services can be cut, interrupted, or affected by natural disasters. Furthermore, when using a SaaS model, the EHR software usually runs within the Web browser—requiring that each computer in the physician's office is running an up-to-date version of Microsoft Internet Explorer or comparable Web browser. Because of the increased reliance on the Internet accessibility of office-based PCs, practice managers and/or IT staff should pay close attention to routine virus scanning, operating system updates, and general system hygiene.

Contingency Planning and Guidance

To help mitigate these events, ONC has created the Contingency Planning SAFER Guide. This free online resource outlines safety practices associated with planned or unplanned EHR unavailability and highlights processes and preparations that can minimize the frequency and impact of such events. The guide includes a checklist of recommended practices for self-assessment and a supporting worksheet to identify action steps. Included in the guide are suggestions on how to replace key EHR functions during downtimes, recovery procedures, and testing and

monitoring strategies. The guide also emphasizes that any contingency plan requires coordination with clinical processes and workflows and that clinicians should be involved in these activities to ensure appropriate consensus across an organization.[14]

In addition to this guidance, ONC has developed a comprehensive guide to EHR contracts intended for health care providers. The guide outlines key contract terms, including those related to limited liability, termination or wind down of an EHR agreement, intellectual property disputes, warranties, and disclaimers. The guidance provides text examples of key contract clauses and explains concepts that providers should consider when negotiating terms, including the responsibility for liability. The agency has also created a checklist for negotiating EHR contacts, which explains key issues to consider, such as data ownership and troubleshooting due to technology errors and system downtime. ONC is also considering publishing model contract language to further facilitate provider and vendor relationships. Beyond ONC, other resources are available to physicians to facilitate the development and negotiation of EHR contracts, including guidance published by the Medical Society of the State of New York.

Medical specialties have also developed guidance on how to handle system downtime.[15] In particular, the American Academy of Family Physicians (AAFP) has provided guidance to address scheduled downtime, short and long-term system outage, data loss, end of life, and back-up processes. This guidance provides specific interventions that should be taken and discussed with EHR vendors, including responsibilities of the vendor to provide physician access to patient data in a usable form when switching systems and differences in responsibilities for backing up data depending on the type of EHR employed.[16]

CURRENT AMA POLICY

Our AMA has numerous and extensive policy on EHRs and the MU program. This policy has supported our extensive advocacy to change and improve MU requirements and the EHR certification process, as well as encouraged more interaction with EHR vendors. A full listing of existing AMA policy related to this Board Report is included as the appendix.

DISCUSSION

Our AMA is making progress in persuading the Administration, lawmakers, and other stakeholders that greater attention is needed on issues such as flexibility, EHR usability, and security. In particular, the Acting Administrator of CMS, Andrew Slavitt, and the National Coordinator for Health IT, Karen DeSalvo, MD, announced significant changes for the MU program in the future, including allowing flexibility to customize health IT, leveling the technology playing field, and focusing on real-world uses of the technology.[17] Importantly, CMS has signaled that MACRA provides the agency with the authority to move the MU program away from a pass-fail structure and towards a more flexible approach within MIPS.

These changes, however, will take time. In the meantime, physicians need support to handle new technology risks, including system downtime and technology errors. As this report documents, there are already many resources available and targeted to physicians, including MU hardship exemptions for technology failures and various sources of vendor contract guidance. Rather than creating more of the same, the problem may be that physicians are unaware of these tools or feel uncomfortable using them to negotiate with vendors. Accordingly, our AMA should continue to educate and teach physicians about how to handle these situations. Providing information in a clear and more simplified manner may help physicians to take advantage of these resources and better use them to meet MU requirements and improve relationships with EHR vendors.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 224-A-15, 227-A-15, and 228-A-15, and Substitute Resolution 224-A-15 and the remainder of the report be filed.

1. That our American Medical Association continue to work with the Centers for Medicare & Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs.

2. That our AMA compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions.

REFERENCES

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5 CMS. 2016 Medicare Electronic Health Record (EHR) Incentive Program Payment Adjustment Fact Sheet for Eligible Professionals. Available at https://www.cms.gov/Regulations-and Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_PaymentAdjustmentFactSheet.pdf
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Appendix - Current AMA Policy

D-478.975 - Maintenance Payments for Electronic Health Records
Our AMA: (1) will advocate for inclusion of payment supplements in the current and proposed payment systems specifically to cover the costs of maintaining (including upgrades of) electronic health records (EHRs) at a national level by whatever means available; and (2) will evaluate and monitor the cost to physicians and their practices of maintaining and upgrading EHRs.

D-478.976 - Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians
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 make available the findings of the AmericanEHR Partners survey and report back to the House of Delegates.

D-478.977 - Exam Room Computing and Patient Physician Interactions
Our AMA will make physicians aware of tips and resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions through AMA publication vehicles, and encourages physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys to provide feedback on how their own patients experience the use of computers in the examination room.

D-478.978 - Electronic Health Record "Lemon Law"
Our AMA will pursue possibilities, consistent with our strategic direction and existing guidelines for working with third parties, to develop tools, accessible to all AMA members, which can help physicians in the selection and evaluation of electronic health records.

D-478.982 - Redefine "Meaningful Use" of Electronic Health Records
1. Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation. 2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.

D-478.990 - Clinical Information Technology Assistance
Our AMA will seek a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including electronic medical record systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors.

D-478.991- Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs
Our AMA will: (1) develop contracting guidelines for physicians considering accepting or donating Electronic Medical Records and Electronic Health Records systems (EMRs/EHRs) from or to hospitals and health care systems; (2) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (3) encourage interoperability of information systems used by hospitals and health care facilities.

D-478.992 - Health Information Technology Purchasing Guidance
Our AMA will help educate physicians via the AMA web site and appropriate AMA publications about issues to consider when purchasing health information technology (HIT) systems, including ensuring the availability of adequate technical support.

D-478.994 - Health Information Technology
Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; (3) support initiatives to ensure interoperability among all HIT systems; and (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

D-478.995 - National Health Information Technology
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians? practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance

transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

D-478.996 - Information Technology Standards and Costs
Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

H-478.991- Federal EMR and Electronic Prescribing Incentive Program
Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.

11. PRINCIPLES FOR HOSPITAL-SPONSORED ELECTRONIC HEALTH RECORDS (BOARD OF TRUSTEES REPORT 1-I-15)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

At the 2015 Interim Meeting, the House of Delegates (HOD) referred additional recommendations to Board of Trustees Report (BOT) 1-I-15, "Principles for Hospital-Sponsored Electronic Health Records," for report back at the 2016 Annual Meeting. These recommendations ask:

> That our AMA advocate that medical practices are the ultimate custodians of individual and aggregate patient information and should have unfettered access to their data; or alternatively
>
> That our AMA advocate that the physician or physician group is the ultimate custodian of individual and aggregate patient information and should have unfettered access to their data if a physician or physician group elects to terminate their use of a hospital sponsored EHR.

The following Policy D-478.973 was adopted:

1. That our American Medical Association promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. That our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. That our AMA work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. That our AMA advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

This report focuses on problems physicians currently face in accessing and porting their data and addresses the definition of a data custodian.

BARRIERS TO DATA ACCESS AND PORTABILITY

As outlined in Board of Trustees Report 1-I-15, there exist several significant barriers to exchanging, accessing, and transporting data. The report noted the impact of EHR certification, costs, and technology barriers that generally impede interoperability, ownership, and data transport across all systems. In addition, the report also addressed the specific obstacles associated with subsidized or donated EHRs, noting how competition, unaffiliated systems, as well as privacy and security concerns can block data flow. To address these problems, the report recommended that our AMA advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship. The HOD adopted this recommendation during the 2015 Interim meeting.

BOT Report 1-I-15 built off of more general findings in BOT Report 18-A-14, which further outlined the obstacles and costs associated with transitioning data stored in EHRs. BOT Report 18-A-14 highlighted problems with data migration in significant detail as well as ongoing AMA advocacy related to this problem. It concluded that our AMA should seek to incorporate EHR data portability as part of the ONC certification process and collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. The HOD adopted these recommendations during the 2014 Annual Meeting. See Policy D-478.995.

AMA POLICY

Several different AMA policies already address the concern of physician ownership and access to their data. H-315.974, states that, regardless if data is stored physically or electronically, our AMA should advocate for physician ownership of all data created, established, and maintained by a physician practice. Other relevant AMA policy, such as H-478.994 and H-315.983, further express the need to ensure physicians can respond to patient access requests and makes interoperability of EHRs an AMA priority. Finally, H-315.972 specifically addresses the situation of what should occur to data at the end of a business relationship, stating that clinical information should be made available to the clinician in a usable form. A full listing of these policies is included as an appendix to this report.

DATA CUSTODIAN

The additional recommendations referred by the HOD for Board Report 1-I-15 echo existing AMA policy and the previous Board reports' recommendations in seeking to ensure physician data ownership and access both generally and when a physician or group elects to terminate their use of a hospital sponsored EHR. The main difference in the referred recommendations is the use of the word "custodian" to describe the relationship between the physician and the information.

The term custodian is not used or defined in the Meaningful Use (MU) or Health Insurance Portability and Accountability Act (HIPAA) statutes or regulations. Without a legal meaning, the term custodian is more of an industry term; however, it lacks a single consistent definition.[1] Oftentimes, the terms "data steward," "data owner," "data manager," and "custodian" are considered to be synonyms; however, other times these terms are explicitly defined in contracts and other legal agreements to have discrete and separate meanings. Typically the custodian role is thought of as ensuring the security of the data, including tasks that often are delegated to health information technology experts or vendors rather than the individual physician. This term may also carry legal connotations that the custodian of the data is the entity primarily responsible for protecting against technological, cyber, and other threats,[2] activities that are actually beyond the expertise and purview of most physicians.

In addition, many patients and patient advocates are beginning to use the term custodian to describe their role in managing health information.[3] Patients recognize that moving from paper to electronic records can facilitate their ability to access and manage their own health care data. Many are calling for greater use of personal health records (PHRs)—a record controlled by the individual that may include health information from a variety of sources, including multiple health care providers, caregivers, and the patients themselves.[4] The patient is then defined as the "custodian" of the PHR, placing a new emphasis on the ability for patients to control and manage their information as opposed to having physicians or other parties as the only entities with direct access to this data.

DISCUSSION

Limitations placed on physicians to extract data from their systems impede care coordination and the development of new delivery models, which diminishes the value associated with the use of an EHR. This is why existing AMA policy has sought to address these concerns by seeking improvements to interoperability and data portability as well as clarifying physician data ownership. These broad policies already cover the intent of the additional recommendations proposed to Board Report 1-I-15. In addition, Board Report 1-I-15 further enhanced existing policy by specifically addressing the concern of accessing data when sponsoring institutions withdraw their support. For these instances, the report adds that our AMA advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship. This new policy therefore further supports existing AMA efforts to address this concern.

Importantly, these existing policies avoid framing physicians as the "custodians" of patient data, which may be misinterpreted by stakeholders and/or convey a sense of legal obligation related to the security of the data. Furthermore, avoiding this term may prevent new conflict with patients who may feel this statement is impinging on their right to manage and access their own information. In sum, the intent of these recommendations is more effectively and accurately addressed by existing AMA policy and ongoing advocacy efforts. Adopting new policy to convey physicians as custodians of data may create confusion or, worse, may connote additional obligations or inadvertent opposition to ongoing advocacy efforts by other stakeholders.

RECOMMENDATION

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

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4 Office of the National Coordinator (ONC). Personal Health Records: What Health Care Providers Need to Know. Accessed February 18, 2016. Available at https://www.healthit.gov/sites/default/files/about-phrs-for-providers-011311.pdf.

Appendix - Current AMA Policy

H-315.974 Guiding Principles, Collection and Warehousing of Electronic Medical Record Information
Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

H-478.994 Health Information Technology
Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.

H-478.988 Data Ownership and Access to Clinical Data in Health Information Exchanges
1. Our AMA: (A) will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE; (B) will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization; (C) will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data; (D) will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and (E) encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues. 2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures. 3. Our AMA

will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice. 4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices.

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.

D-478.995 National Health Information Technology
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

D-478.991 Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs
Our AMA will: (1) develop contracting guidelines for physicians considering accepting or donating Electronic Medical Records and Electronic Health Records systems (EMRs/EHRs) from or to hospitals and health care systems; (2) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (3) encourage interoperability of information systems used by hospitals and health care facilities.

D-478.994 Health Information Technology
Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; (3) support initiatives to ensure interoperability among all HIT systems; and (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

H-315.972 HIPAA Business Associate Contracting, Domestic and Foreign, and Foreign Outsourcing
1. Our AMA encourages physicians who have entered or who are considering entering a business associate agreement (BAA) to undertake careful due diligence regarding the business associate and to consider with legal counsel the inclusion of contractual provisions such as: a. strong confidentiality clauses; b. required steps to mitigate any harmful effects of wrongful use or disclosure of protected health information (PHI); c. assurance that, upon the contract's termination, all PHI is returned to the covered entity, and no copies are retained by the business associate, except as required for legal or audit purposes; d. indemnification of the covered entity against any losses caused by a business associate; e. the business associate's procurement of specified types of liability insurance which may either protect the covered entity or enable the business associate to meet its indemnity; f. posting a surety bond (a.k.a. performance bond) to ensure faithful performance of the BAA by the business associate; or g. physicians should take care that the original contract should contain provisions addressing the costs involved with the return and maintenance of the PHI at or after the end of the contract term. 2. Our AMA supports legislation and/or regulation requiring all third parties who receive and maintain clinical information from a clinician to make those data available to the clinician in usable form at the end of the business relationship.

12. REDUCING GUN VIOLENCE
(BOT REPORT 7-A-15, SUBSTITUTE RESOLUTION 215-A-14 AND RESOLUTION 224-A-14)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-145.996

INTRODUCTION

At the 2015 Annual Meeting, the House of Delegates (HOD) considered Board of Trustees Report (BOT) 7, Reducing Gun Violence, which responded to the referral of Substitute Resolution 215-A-14 and Resolutions 215-A-14 (sponsored by the Illinois delegation) and 224-A-14 (sponsored by the New England delegation). At the 2014 Annual Meeting, the HOD referred Substitute Resolution 215, which asked that our American Medical Association (AMA) support congressional passage of legislation requiring licensing and background checks for all buyers of firearms. As originally introduced, Resolution 215-A-14, "Reducing Gun Violence," called on our AMA to support congressional passage of legislation requiring criminal background checks for all gun sales, public and private. Resolution 224-A-14, "Firearm Violence," asked that our AMA support federal efforts to promote legislation to make licensing and background checks mandatory for all firearm purchases and transfers regardless of the seller or individual making a transfer.

During the reference committee hearing on BOT Report 7-A-15, a representative from the Board testified that the recommendation in Report 7, i.e., "That our AMA support legislation requiring background checks for all purchasers of firearms," builds upon existing AMA policy that supports increasing the safety of firearms and their use and reducing and preventing firearm violence. However, there was strong testimony both for and against adoption of the recommendation as drafted, with some testimony presented that the recommendation was not strong enough and did not include the transfer of firearms or firearms purchased at trade shows, and other testimony presented that the recommendation was too broad and could extend to transfers of firearms, including antiques, to family members, or individuals who already possess the requisite clearance. Given the diverse perspective, the reference committee recommended referral of the recommendation in BOT Report 7-A-15. At the HOD, the following Substitute Recommendation offered by a delegate was debated: "That our AMA strongly support requiring criminal background checks for all firearm purchases, including, but not limited to, sales by gun dealers, sales at gun shows, and private sales between individuals." The HOD then voted to refer the Substitute Recommendation for the development of a Board report to the HOD at the 2016 Annual Meeting.

This report provides background on federal law on regulating firearm purchases through background checks and licensing, state firearm background check laws and pending legislation, summarizes existing AMA policy, and recommends modifying existing AMA policy.

BACKGROUND

Federal Law on Background Checks and Licensing for Firearm Purchases

Under the Brady Handgun Violence Prevention Act of 1993 (Brady Act), federally licensed firearms dealers are required to perform background checks on prospective firearms purchasers to ensure that the firearm transfer would not violate federal, state, or local law. As originally enacted, the Brady Act included interim provisions that applied to handgun sales only, which were implemented in 1994. The permanent provisions of the Brady Act went into effect in 1998, establishing the National Instant Criminal Background Check System (NICS) and extending the Brady Act's application to purchasers of long guns and persons who redeem a pawned firearm. Since the background check system began, over 196 million background checks have been performed, and over two million firearms sales to prohibited purchasers have been denied.[1]

Federal law prohibits felons, those convicted of domestic violence misdemeanors, individuals with certain mental health histories (e.g., commitment to psychiatric facilities), and certain others from acquiring or possessing firearms. Under the federally-regulated system of background checks, individuals who purchase firearms from licensed firearms dealers and pawnbrokers must provide identification and undergo a background check to verify that they

are not in one of the prohibited categories. In over 90 percent of cases, the background check is completed within minutes, but in some circumstances, where certain information may be missing, the purchaser may have to wait up to three business days before acquiring the firearm.[2] A permanent record of the sale is kept by the dealer, in case the firearm is later used in a crime. Federal law does not require licensing of gun owners or purchasers.

Federal law on background checks applies only to firearm purchases from federally licensed firearms dealers and does not apply to sales and transfers of firearms by unlicensed sellers. Under federal law, persons "engaged in the business" of dealing in firearms must be licensed; however, a person is not engaged in the business if he or she only makes "occasional sales, exchanges, or purchases of firearms for the enhancement of a personal collection or for a hobby, or who sells all or part of his personal collection of firearms."[3] The National Institute of Justice estimated, in a 1997 report, that 40 percent of all firearms sold in the US are transferred by unlicensed private parties.[4] These sales occur at gun shows, over the internet, through classified ads, and by word of mouth. With such sales, no identification is required, no background check is required, and no record of the transaction is kept.

Surveys have shown that the majority of Americans (89 percent) and gun owners (84 percent) support expanding background check requirements for gun sales.[5] Recent studies suggest that universal background checks and firearm purchasing licensing affect homicide rates by reducing the availability of guns to criminals and other prohibited groups,[6] and that identifying prohibited persons through background checks reduces their chances of committing a violent crime by 25 percent.[7]

In April 2013, during Senate debate on strengthening federal laws on background checks, Senators Joe Manchin (D-WV) and Pat Toomey (R-PA) proposed an amendment to pending legislation that would have extended background checks to any gun transfer at a gun show or event, or through advertisements, the Internet, or in publications. Although 54 members of the Senate voted to proceed to debate on the amendment, 60 votes were required, and the amendment died. This was the last attempt in Congress to expand background checks to private sales; any further attempts would be unsuccessful given the current composition of Congress.

In light of congressional inaction, President Obama issued a series of executive actions to be taken on gun violence prevention in January 2016. These actions include: clarifying what it means to be "engaged in the business" of selling guns, thereby narrowing the loophole that allows many private sales of firearms to occur without a background check; ordering improvements to the NICS to make the system more accurate, up-to-date, and efficient; requesting additional resources for the Bureau of Alcohol, Tobacco, and Firearms, expanding domestic violence outreach efforts, and requiring reporting of lost and stolen firearms; increasing mental health treatment and encourage better reporting of relevant records to the NICS; and ordering the Departments of Justice, Defense, and Homeland Security to research smart gun technology.

State Laws on Background Checks and Pending Legislation

While 18 states and the District of Columbia (DC) have extended the background check requirement beyond federal law to require background checks to some private sales, the scope of these laws vary. Eight states and DC have enacted comprehensive universal background checks at the point of sale for all transfers of all classes of firearms, including purchases from unlicensed sellers (California, Colorado, Connecticut, Delaware, New York, Oregon, Rhode Island, and Washington). Maryland and Pennsylvania laws do the same, but are limited to handguns. One state (Illinois) requires a background check whenever a firearm is sold at a gun show. Four states (Hawaii, Illinois, Massachusetts, and New Jersey) require any firearm purchaser, including a purchaser from an unlicensed seller, to obtain a permit issued after a background check, and four more states (Iowa, Michigan, Nebraska, and North Carolina) do the same only for handguns.

<u>Background Checks at the Point of Transfer</u>

The most comprehensive approach to ensuring that guns are not sold to prohibited persons is through a requirement for a background check at the point of transfer of any firearm. Eleven states have this requirement for all guns, and six states require this for handguns. The simplest way to accomplish this is to require private sellers to process gun transfers through licensed gun dealers or law enforcement. California and Rhode Island have had this requirement for over two decades while six states recently adopted this approach (Colorado, Connecticut, Delaware, New York, Oregon, and Washington). The Bureau of Alcohol, Tobacco, Firearms & Explosives issued a guidance document in

2013 that sets out a streamlined procedure for gun dealers to use to conduct background checks on behalf of unlicensed sellers of firearms. [8]

California,[9] Colorado,[10] Delaware,[11] New York,[12] Oregon,[13] and Washington[14] require all firearm transfers to be processed through licensed dealers, who must conduct background checks on prospective firearm purchasers. Rhode Island requires all sellers to obtain a completed application form from the prospective purchaser, and to submit the form to law enforcement for purposes of conducting a background check.[15] Connecticut requires any person transferring a firearm to either submit a form to law enforcement or conduct the transfer through a licensed dealer, so that a background check is conducted for every sale or transfer.[16] In the District of Columbia, firearms may be transferred only by or to a licensed dealer.[17] Maryland[18] and Pennsylvania[19] require a background check on every prospective transferee of a handgun, which may be conducted by a licensed dealer or a designated law enforcement agency. Finally, Illinois,[20] and Oregon[21] require a background check before the sale or transfer of a firearm at a gun show.

Almost all of the existing state laws that require unlicensed sellers to conduct background checks on firearm purchasers apply this requirement to "transfers," as well as sales. Since guns are often transferred to people who do not pay for them, such as in criminal enterprises or as part of guns-for-drugs trades, state laws include the broader term "transfers" in order to allow prosecutors to bring charges against a person for failing to conduct a background check in these circumstances. However, many existing state laws that require a background check for transfers or sales by an unlicensed individual usually include certain exceptions, including gifts or loans among close family members, transfers made from a decedent's estate, transfers to law enforcement officers and members of the military, and limited loans for lawful purposes. There are at least seven states with exemptions for giving guns to family members (e.g., Colorado, California, Delaware, Illinois, Nebraska, Pennsylvania, and Washington).

Pending State Legislation: Background Checks at the Point of Sale or Transfer

In 2016, at the time of this report, bills are pending in 12 states that attempt to require some type of background checks on private sales (Arizona H.B. 2091, S.B. 1339, HCR 2007, Iowa H.F. 77, Missouri H.B. 1596, Minnesota H.B. 2415, New York S.B. 2445, Ohio H.B. 78, Pennsylvania H.B. 1010/S.B. 777, South Carolina H.B. 3033, H.B. 4399, Tennessee H.B. 2365/S.B. 2311, Vermont H.B. 250/S.B. 31, Virginia H.B. 1923/S.B. 768, and Wisconsin A.B. 247/S.B. 159). These bills require all firearm transfers to be processed through licensed dealers who must conduct background checks on prospective firearm purchasers. If the person selling the firearm is not a licensed firearms dealer, the seller would be required to transfer the firearm to a licensed firearms dealer until the background check is completed. Additionally, four states have bills requiring long guns to be processed through licensed gun dealers (Maryland H.B. 692/S.B. 947, Michigan H.B. 4590/S.B. 4781, New Hampshire L.S.R. 526, and New Jersey A.B. 1212).

Pending State Legislation: Background Checks at Gun Shows

At the time of this report, five states have pending legislation requiring background checks to be conducted at gun shows (Florida S.B. 370, Georgia H.B. 843, New Mexico H.B. 51, South Carolina H.B. 3033, and Virginia H.B. 1604/S.B. 694). Kansas S.B. 25 would require background checks at gun shows and over the Internet. The bill does, however, exclude the requirement for background checks when there is a transfer of an antique firearm, gifts or transfers between family members, or transfers through inheritance. Virginia H.B. 1386 would set up a program with the state police to conduct voluntary criminal background checks at gun shows prior to purchase.

Pending State Legislation: Repeal Background Check Requirements

At the time of this report, three states have pending legislation to repeal background check requirements. New York A.B. 2391/S.B. 1556 would repeal background check requirements established under The SAFE Act. Oregon H.B. 4028 creates certain exemptions to the requirement that a firearm be transferred through a licensed firearms dealer. Washington H.B. 1245 would repeal background check requirements at gun shows. Washington H.B. 1506/S.B. 5579 would exempt the transfer of a firearm between a private security guard and his or her private security company employer from background check requirements, if the transfer is in the course or scope of employment or official duties. Finally, Washington H.B. 1886 would repeal Initiative Measure No. 594, which required background checks for all gun sales and transfers.

State Legislation: Background Checks Vis-a-vis Permit Requirements

Another method to expand background checks is to require a state permit or license in order to purchase a firearm. In four states, the background check is done by requiring a potential purchaser to obtain a license or permit before purchasing any firearm from any seller (Hawaii,[22] Illinois,[23] Massachusetts,[24] and New Jersey[25]) and four states require permits solely for handguns (Iowa,[26] Michigan,[27] Nebraska,[28] and North Carolina[29]).

Pending State Legislation: Licensing

At the time of this report, three states have pending legislation to amend gun licensing laws as they relate to concealed handguns. Illinois H.B. 1405 would amend the Firearm Owners Identification Card Act. The bill would require a seller who is not a federally licensed importer, manufacturer, or dealer and who desires to sell or transfer a firearm that may be concealed to a purchaser who is not a federally licensed importer, manufacturer, or dealer, to do so only through a federally licensed firearms dealer who would be required to conduct a background check on the prospective purchaser. New Jersey A.B. 1738 is a bill that makes changes to the way firearms purchaser identification cards, permits to purchase handguns, and concealed carry permits are issued so that they can be electronically validated and verified. Virginia S.B. 187 requires anyone purchasing a firearm to obtain a firearm transfer permit. The purchaser must be 21 years of age and pass a background check.

State Laws Requiring Waiting Periods

Laws imposing waiting periods require that a specified number of days elapse between the time a firearm is purchased and it is physically transferred to the purchaser. The goals of a waiting period are to: (1) give law enforcement officials sufficient time to perform a background check; and (2) provide a "cooling off" period to help guard against impulsive acts of violence and suicides. In fact, research published in the American Journal of Public Health showed that states with a law in place that required a waiting period for the completion of handgun sales had 27 percent fewer suicides per capita and 51 percent fewer firearm suicides.[30]

AMA POLICY

Our AMA has numerous, long-standing policies that support increasing the safety of firearms and their use, and reducing and preventing firearm violence. Our AMA "recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths" (H-145.997). Specifically related to background checks, AMA policy supports legislation calling for a waiting period before purchasing any form of firearm in the US (H-145.991, H-145.992, and H-145.996), and supports requiring background checks for all handgun purchasers (H-145.991, H-145.996). Moreover, AMA policy supports stricter enforcement of present federal and state gun control legislation, and the imposition of mandated penalties for crimes committed with the use of a firearm, including the illegal possession of a firearm (Policy H-145.999). All of these policies were originally adopted in the late 1980s, when there was a national focus on handguns in part because access to relatively inexpensive handguns had led to an increase in rates of homicide, especially among young people. These policies have been repeatedly reaffirmed since then by the HOD.

DISCUSSION

Firearm-related mortality and morbidity continue to be major public health problems in the US. According to the Centers for Disease Control and Prevention, over 100,000 people are victims of gunshot wounds every year in the US, with more than 32,000 people dying from their injuries.[31] Every day, 20 children and adolescents are sent to the hospital as a result of firearm injuries,[32] and 88 deaths per day are due to firearm-related suicides, homicides, and accidents.[33] Firearm homicide ranks in the top five causes of death for Americans between the ages of five and 44, while firearm suicide remains in the top four causes of death for all age groups over age 14, and ranks as the third leading cause of death for children ages 10 to 14. In 2015, for the first time, firearm deaths were expected to take more lives in the 15 to 24 age group than motor vehicle accidents.[34] Since the Sandy Hook mass shooting in December 2012, there have been at least 170 school shootings in America and a report by the Urban Institute showed that in the single school district of Washington, DC, there were at least 336 gunshots in the vicinity of schools over a single school year.[35] Mass shootings in 2015 and 2016 continue to focus public attention on cities and

towns across the country, including Roseburg (OR), San Bernadino (CA), and most recently, Kalamazoo (MI) and Hesston (KS), just to name a few.[36]

Despite such sobering statistics and the public outcry after Sandy Hook and other recent mass shootings for action by Congress to expand background checks for firearm purchases, there is little chance given the current political environment for any congressional action in the foreseeable future to strengthen background check requirements or require licensing for firearms purchasers. The focus of attention for further legislative initiatives on preventing and reducing firearm violence has been, and will continue to be, at the state and local levels. As discussed above, a number of states have extended background checks to all private sales of firearms; in such cases, all firearm sales are processed through licensed dealers who must conduct background checks on prospective firearm purchasers. If the person selling the firearm is not a licensed firearms dealer, the seller would be required to transfer the firearm to a licensed firearms dealer until the background check is completed. While some states do require licensing or permits for buyers in lieu of or in addition to requiring the seller to conduct background checks, the most straightforward method to ensure that buyers of firearms undergo universal background checks is to require them at the point of sale. In addition, as previously noted, while state laws often include the broader term "transfers" instead of sales, many existing state laws that require a background check for transfers or sales by an unlicensed individual usually include certain exceptions, including gifts or loans among close family members, transfers made from a decedent's estate, transfers to law enforcement officers and members of the military, and limited loans for lawful purposes.

CONCLUSION

In summary, your Board believes it would be consistent with our AMA's existing policies on background checks, and a logical extension of such policies, to modify existing AMA policy that advocates and encourages legislation that enforces a waiting period and background checks for all purchasers of handguns, and extend such policy to all firearm purchasers. Your Board also notes that adopting such policy would be consistent with recent action taken by the American Psychiatric Association, which adopted a new policy statement that in part calls for requiring background checks (and waiting periods) on all gun sales or transactions, as well as with a call to action on firearm-related injury and death in the US issued in 2014 by eight medical organizations—including the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics—and the American Bar Association.[37] Our AMA has been asked to join the call to action but has not been able to do so because our existing policy does not support background checks on all firearm purchases. For these reasons, your Board recommends adopting the policy set forth below.

RECOMMENDATION

The Board of Trustees recommends that policy H-145.996 be amended by addition and deletion to read as follows in lieu of Substitute Recommendation, BOT Report 7-A-14, Substitute Resolution 215-A-14 and Resolutions 215-A-14 and 224-A-14, and that the remainder of this report be filed.

> H-145.996 ~~Handgun~~ Firearm Availability
> The AMA (1) advocates a waiting period and background check for all firearm purchasers ~~handgun purchasers~~; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers ~~handgun purchasers~~; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

REFERENCES

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2 Federal Bureau of Investigation. National Instant Criminal Background Check System (NICS) Operations 2011. Washington, DC: Federal Bureau of Investigation, 2012.
3 18 U.S.C. §§ 922(t), 923(g), and § 921(a)(21)(C).
4 Philip J. Cook & Jens Ludwig, Guns in America: National Survey on Private Ownership and Use of Firearms, U.S. Department of Justice, National Institute of Justice Research in Brief 6-7 (May 1997), available at https://www.ncjrs.gov/pdffiles/165476.pdf.

5 Commonsense Solutions, page 8; Webster DW, Crifasi CK, and Vernick JS. Effects of the Repeal of Missouri's Handgun Purchasing Licensing Law on Homicides. Johns Hopkins Center for Gun Policy and Research, published in Journal of Urban Health (April 2014), Vol. 91, Issue 2, pp 293-302.
6 Webster, et al.
7 Wintemute G. Background Checks for Firearm Transfers. Violence Prevention Research Program, University of California, Davis. 2013.
8 Bureau of Alcohol, Tobacco, Firearms & Explosives, Record-keeping and background check procedures for facilitation of private party firearms transfers, ATF Proc. 2013-1, at https://www.atf.gov/sites/default/files/assets/pdf-files/atf_proc._2013-1_-_private_firearms_transfers_through_ffls.pdf.
9 Cal. Penal Code §§ 27545, 27850-28070
10 Colo. Rev. Stat. § 18-12-112. 2013 Colo. H.B. 1229. See also Colo. Rev. Stat. §§ 12-26.1-101 – 12-26.1-108 (pre-existing law requiring a background check before a firearm is sold at a gun show).
11 Del. Code tit. 11, § 1448B, tit. 24, § 904A.
12 N.Y. Gen. Bus. Law § 898. 2013 NY ALS 1. See also N.Y. Gen. Bus. Law §§ 895-897; N.Y. Penal Law § 400.00 (pre-existing law requiring a background check before sale of a firearm at a gun show).
13 Or. Rev. Stat. §§ 166.412, 166.432, 166.434, Or. Admin. R. 257-010-0010 et seq.
14 Initiative Measure No. 594, available at http://sos.wa.gov/_assets/elections/initiatives/FinalText_483.pdf.
15 R.I. Gen. Laws §§ 11-47-35 – 11-47-35.2.
16 Conn. Gen. Stat. §§ 29-33(c), 29-36l(f), 29-37a(e)-(j). 2013 Ct. ALS 3. See also Conn. Gen. Stat. § 29-37g (pre-existing law requiring a background check before a firearm is sold at a gun show).
17 D.C. Code Ann. § 7-2505.02.
18 Md. Code Ann., Pub. Safety §§ 5-101(t), 5-124. Maryland's requirement applies to "regulated firearms," which is defined to include handguns and assault weapons. However, assault weapons are now generally banned in Maryland.
19 18 Pa. Cons. Stat. § 6111(b), (c), (f)(2).
20 430 Ill. Comp. Stat. 65/3, 65/3.1.
21 Or. Rev. Stat. §§ 166.432 – 166.441.
22 Haw. Rev. Stat. Ann. §§ 134-2, 134-13.
23 430 Ill. Comp. Stat. 65/1 – 65/15a, 720 Ill. Comp. Stat. 5/24-3(k).
24 Mass. Gen. Laws ch. 140, §§ 121, 129B, 129C, 131, 131A, 131E, 131P.
25 N.J. Stat. Ann. § 2C:58-3.
26 Iowa Code §§ 724.15 – 724.20.
27 Mich. Comp. Laws §§ 28.422, 28.422a.
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Appendix - Current AMA Policy

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. (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)

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. (Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

H-145.996 Handgun Availability
The AMA (1) advocates a waiting period and background check for all handgun purchasers; (2) encourages legislation that enforces a waiting period and background check for all handgun purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. (Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level. (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

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. (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)

13. RESTRICTIVE COVENANTS IN PHYSICIAN CONTRACTS (RESOLUTION 203-A-15)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-383.987

INTRODUCTION

At the 2015 Annual Meeting, the House of Delegates (HOD) referred Resolution 203-A-15, "Model State Legislation Eliminating Restrictive Covenants in Physician Contracts". Resolution 203-A-15, introduced by the Virginia Delegation, asks that our American Medical Association (AMA) study the development of model state legislation that eliminates restrictive covenants from physician employment agreements and contracts.

During testimony before the Reference Committee, it was recognized that issues raised by Resolution 203-A-15 may not be an issue where "one size fits all." Therefore, given the complexity of the current employment environment for physicians, the need and opportunity for physician education on this and other contractual issues, and the commitment of our AMA to ensure the viability of all physician practices, the HOD recommended referral of Resolution 203-A-15 to the Board of Trustees.

While restrictive covenants can also appear outside of physician employment, e.g., independent contractor relationships that physicians have with hospitals, this report will focus on restrictive covenants within the physician employment context. Additionally, although there are different types of restrictive covenants, based on the scope of Resolution 203-A-15 this report will discuss restrictive covenants that place time and geographic restrictions on physicians post-employment.

BACKGROUND

With respect to physicians, a restrictive covenant is an agreement between a physician and his or her employer. Typically, the covenant prevents the physician from practicing medicine in competition with his or her former employer, by prohibiting the physician from practicing medicine within a defined geographic area for a specific period of time following the termination or conclusion of the physician's employment. For example, a restrictive covenant in a physician employment agreement with a physician group practice or hospital may state that, upon termination of employment, the physician may not practice within five miles of the practice or hospital for two years from the date on which employment ended. Restrictive covenants, also known as non-compete agreements, are frequently included as part of physician employment agreements.

Employer's Reasons for Requiring Restrictive Covenants

Employers use restrictive covenants to protect their business interests. These business interests can take several forms. For example, an employer medical practice may train the physician, make referral sources and contacts available to the physician, give the physician access to patients and patient lists, market the physician in the community, and provide the physician with proprietary practice information—all to help the physician build up his or her practice. Physician employers like hospitals and group practices use restrictive covenants to prohibit a physician from leaving and then establishing a competing practice, or joining a competing practice or hospital, in the former employer's vicinity all the while benefitting from information, training, patient contacts, and other resources provided by the physician's former employer. Restrictive covenants give the employing medical group or hospital the freedom and security to invest significant resources in the employed physician's success, without the employer having to worry that the physician will later leave the practice or hospital after the physician has developed a significant patient base, taking those patients with him or her. Because of the commitment of practice resources involved, a medical group or hospital may be particularly interested in having a restrictive covenant in place when it is hiring a physician straight out of residency or from some other setting where the physician has had no prior experience in private practice. A practice or hospital may also want to use a restrictive covenant to protect itself from the departing physician's use and/or disclosure of the practice's proprietary business information, particularly if the physician had a leadership, management, or other key role in the practice that would have made him or her privy to sensitive information.

Concerns regarding restrictive covenants: Challenges to the employed physician and potential impact on the patient-physician relationship

Restrictive covenants can pose challenges to physician employees. Enforcement of a restrictive covenant could force a physician and his or her family to move out of the geographic area where the physician and family members may have developed significant community relationships. Additionally, restrictive covenants may not always adequately recognize the contributions that an employed physician may have made to a medical practice or hospital with regard to his or her professional skills, reputation, and patient relationships, and may overestimate the employer's investment in education and training of that physician. (On the other hand, restrictive covenants may benefit employed physicians, e.g., in cases where a hospital, practice, or other employer might not even consider hiring a physician just out of residency unless it can employ a reasonable restrictive covenant.)

Another issue regarding restrictive covenants pertains to their potentially disruptive impact on the patient-physician relationship. For example, some patient-physician relationships are long-standing, which may occur when a patient has a chronic condition that has been treated by his or her physician for many years. If the physician's employment ends, and a restrictive covenant forces the physician to leave the area, that relationship may come to an end. Although the patient may be able to obtain care from another physician in the area, the confidence and trust that the patient had with his or her prior physician may no longer exist. AMA Ethics Opinion E-9.02, "Restrictive Covenants and the Practice of Medicine," recognizes the ethical concerns that restrictive covenants may implicate. Opinion E-9.02 does not prohibit restrictive covenants in physician employment contracts. However, E-9.02 states, in part, that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician.

AMA POLICY

Our AMA has several policies that address restrictive covenants. In addition to the portion of E-9.02 mentioned, E-9.02 states that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program. H-310.929, "Principles for Graduate Medical Education," states that restrictive covenants must not be required of residents or applicants for residency education. H-295.910, "Restrictive Covenants During Training," strongly urges residency and fellowship training programs that utilize restrictive covenants to provide written intent to impose such restrictions in advance of the interview process. H-295.901, "Restrictive Covenants in Residency and Fellowship Training Programs," states that physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program. Finally, H-225.950, "AMA Principles for Physician Employment," discourages physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

DISCUSSION

Restrictive covenants are governed by state law, and states vary widely in their treatment of restrictive covenants. A number of states have enacted statutes that regulate restrictive covenants, and some of these laws specifically address the application of restrictive covenants to physicians. Other states may deal with physicians and restrictive covenants solely through judicial decisions.

With respect to those states that have enacted restrictive covenant statutes, only Colorado, Delaware, and Massachusetts, appear to prohibit the application of restrictive covenants to physicians.[1] In addition to prohibiting an employer from imposing post-employment geographic and temporal restrictions, the Massachusetts statute also does not allow an employer to require a physician employee to pay the employer compensation (competition compensation) in order to compete with the employer after the employment relationship ends. (Delaware and Colorado appear to permit an employer to require such a payment.) Other states, whether by statute or judicial decision, allow the enforcement of restrictive covenants against physicians, although statutes may set out specific requirements that the restrictive covenant must satisfy when applied to a physician. For example, in Texas restrictive covenants are enforceable against a physician if they: (1) allow a physician access to patients' medical records; (2) allow a physician access to a list of patients seen within one year after the contract or employment is terminated; (3) include a reasonable buyout; and (4) do not prohibit a physician from caring for a patient during an acute illness, even after the employment is terminated.[2] In Tennessee, a restrictive covenant is enforceable against a physician if: (1) the duration is two years or less; and (2) the maximum allowable geographic restriction is the greater of: (a) a ten-mile radius from the primary practice site of the health care provider while employed or contracted; or (b) the county in which the primary practice of the health care provider while employed or contracted is located.[3]

While most states allow restrictive covenants to apply to physicians, courts generally are suspicious of restrictive covenants because they constitute a restraint on trade. Consequently, courts place significant limitations on restrictive covenants, so that an employer does not have unfettered discretion when drafting a restrictive covenant. Courts will typically construe any ambiguities in a restrictive covenant against the employer. Courts will only recognize a restrictive covenant if the employer has a legitimate business interest, e.g., a patient base, to protect rather than simply a desire to avoid competition. Additionally, courts will not enforce a restrictive covenant unless its geographic and time period restriction are reasonable. Courts determine the reasonableness of a restrictive covenant on a case-by-case basis. Whether or not a restrictive covenant is reasonable is typically very fact specific, which can be influenced by many variables, e.g., the physician's specialty, whether the employer is located in a rural or urban area, the number of patients in the particular geographic area, etc., and significant variation can exist within a single state. In some states, a court will simply invalidate a restrictive covenant if the court finds that the restrictive covenant is broader than necessary to protect the employer's interests, i.e., if the restrictive covenant is not reasonable. In other states, courts may not throw the entire covenant out. Instead, they may apply what is sometimes referred to as a "blue pencil" to the restrictive covenant, meaning that the court will rewrite an overly broad restrictive covenant into one that, in the court's view, is reasonable. Finally, many states will treat restrictive covenants involving physicians more exactingly than in other contexts because of public policy issues involving medical care, such as: patient access issues; the patient's ability to continue a course of treatment with his or her physician; and physician shortages in the geographic area.

Developing model legislation eliminating restrictive covenants would be complicated due to several factors. First, AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although policy H-225.950 discourages physicians from entering into restrictive covenants, and Opinion E-9.02 states that physicians should not enter into restrictive covenants that place unreasonable restrictions on physicians and patient choice.

Second, AMA members are obviously on both sides of this issue, i.e., as employers (owners in physician practices), and on the other hand, as employees of hospitals or independent practices. Certainly, in recent years there has been an upward trend in physician employment by hospitals. Independent medical groups continue to employ significant numbers of physicians. Employed physicians may well have an interest in the development of model legislation that would eliminate restrictive covenants from all physician employment agreements. However, a large number of physicians continue in private practice, many of whom are in ownership positions or who aspire to ownership. These AMA members may have little interest in our AMA's developing model legislation banning restrictive covenants.

Third, given the fact that the enforceability of restrictive covenants is very fact specific, developing model legislation eliminating restrictive covenants in all circumstances may be much more than is required to address concerns that restrictive covenants may raise in specific circumstances. Certainly, the application of a restrictive covenant may implicate issues discussed in Opinion E-9.02 above as well as those of physician hardship. However, such concerns may not be present in every situation. As already noted, variation not only exists state-to-state, but may also occur significantly within geographic regions within a single state. Thus, the "one size fits all" solution that model state legislation broadly eliminating restrictive covenants represents may not be the most appropriate, tailored means of addressing restrictive covenants issues. Other, more targeted, legislative approaches that also take into account the interests of physician owner's interests may be a more promising approach in terms of AMA members' interests taken collectively.

Our AMA has already developed a number of resources available to employed physicians, including restrictive covenant issues. For example, both our AMA's Annotated Model Physician-Group Practice Employment Agreement and our Annotated Model Physician-Hospital Employment Agreement contain model restrictive covenant language and other resources that help physicians identify, understand, and evaluate the restrictive covenants that are presented to physicians by potential physician practice or hospital employers. Our AMA also conducts webinars and in-person presentations for practicing physicians and residents about physician employment, which always include discussions of restrictive covenants. Our AMA has also developed a suite of model state bills designed to address some of the most common concerns expressed by employed physicians. These bills are available from our AMA's Advocacy Resource Center and are available to state medical associations that may want to have restrictive covenant legislation introduced into their respective state legislatures.

Based on all of the above, we do not recommend that our AMA develop model legislation that would eliminate restrictive covenants in physician employment agreements, for the reasons described in this report. Nevertheless, your Board believes that restrictive covenants in physician employment contracts can raise ethical concerns regarding patient choice and the continuity of the patient-physician relationship, and may impose hardships on employed physicians. Consequently, your Board believes that our AMA should, upon request, provide support to state medical associations and national medical specialty societies that want to address restrictive covenant issues legislatively. Support could include assistance drafting more nuanced legislation that attempts to be cognizant of physicians on both sides of the restrictive covenant issue.

CONCLUSION

In summary, although we understand that restrictive covenants can raise significant concerns for employed physicians and the patient-physician relationship, we believe that developing model state legislation broadly eliminating restrictive covenants may not be the most appropriate means of dealing with those concerns, particularly given the wide-variety in which restrictive covenants are applied (even within a single state) and the fact that AMA members are on both sides of this issue, as employed physicians or as the owners of medical practices that employ physicians. We believe that our AMA should, however, provide support to any state medical association or national medical specialty society requesting assistance in developing state legislation dealing with the important issues that restrictive covenants can raise.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 203-A-15 and that the remainder of the report be filed:

> That our American Medical Association provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.

REFERENCES

1 Colorado Revised Civil Statues Annotated § 8-2-113;6 Delaware Code Annotated § 2707; Massachusetts Annotated Laws Ch. 112, §§12X
2 Texas Business and Commerce Code § 15.50
3 Tennessee Code Annotated § 63-1-148

14. PATIENT MATCHING

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

During its September 2015 meeting, the Council on Legislation heard a report on the growing interest in patient matching efforts to improve data exchange and the interoperability of electronic health records (EHRs). The Council reviewed existing American Medical Association (AMA) policy on this topic and recommended to the Board of Trustees (BOT) that it study this subject and offer recommendations on how our AMA should address this issue moving forward.

This report builds upon BOT Report 23 from the 2010 Annual Meeting that addressed a national master patient identifier as a potential solution for patient matching problems. This informational report more broadly provides background on the numerous ongoing efforts to improve patient matching, including alternatives to a unique patient identifier. It also highlights privacy and security concerns that must be balanced against solutions to improve matching and identification. The report also reviews existing AMA policy relevant to this issue.

BACKGROUND

Accurately identifying patients and correctly matching their data is essential to ensuring interoperability, coordination of patient care, and facilitation of new payment and delivery models. The exchange of patient information relies on incorporating data into the correct patient record. Care coordination cannot occur if treatment and diagnosis decisions are made in the absence of valuable information that could avoid duplicate testing or unnecessary treatment. Ultimately, the goal of patient matching is to ensure that patient Mary Jones, who is 59 years old and diabetic, and Mary Jones, who is 15 years old and healthy, can be distinguished from one another.

Current patient record matching methods, however, cannot achieve a zero percent error rate in which every possible match is correctly made and erroneous matches are avoided.[1] Failure to match patient records occurs for many reasons but often because organizations use different data elements, matching processes, and requirements for standardization. Other issues that lead to unmatched or mismatched records include the quality of data as it is entered into systems at the source of patient registration and the creation of duplicate records for the same patient within a system.

Privacy and Security Concerns

Another challenge in accurately matching patient records is the need to simultaneously secure the data and ensure patient privacy. Often, the more robust patient matching tools require disclosure of specific patient data, which may include sensitive information. In some cases, organizations have used Social Security numbers to identify and match patients (either the full number or last four digits). While this may ensure a patient is correctly identified, it also increases the risk of data breaches and identity theft compared to when organizations simply use a medical identifier

to match patients, which is not directly tied to financial or other important information. Patients also are concerned that they lack consent in how their data is released in order to facilitate patient matching. Consequently, some patients decline to provide Social Security numbers on intake forms, which often results in an organization assigning to the patient a default Social Security number (e.g., 999-99-9999), leading to numerous patients within one organization having the same identifier.

Conversely, incorrectly matching a patient to a health record also has privacy, security, and health care implications.[2] Using matching solutions that have high error rates can lead to wrongful disclosure and treatment based on another patient's health information. Accordingly, any patient matching solution must consider the impact on patient privacy, security, and consent for it to be a viable solution.

Costs

In addition to privacy and security concerns, the cost of patient matching solutions can create challenges. Some organizations develop their own matching methods and algorithms, while others purchase products or use their EHR vendor's product for internal and external matching. The overall cost of the matching methods varies based on the product, whether the facility is matching patients internally or externally across organizations, and the amount of data.

Because no patient matching system is perfect, health systems typically have several people within their medical records department devoted to manually reviewing charts. This process requires locating duplicate reports, resolving incorrect matches, and correcting data errors. Intermountain Medical Center reported that it had calculated the cost of fixing a single duplicate record at $60 in operational costs.[3] Similarly, Sharp Health Care, a group of four acute care hospitals, three specialty hospitals, and two affiliated medical groups, has 10 full-time employees dedicated to investigating, evaluating, and cleaning up duplicate records at an estimated cost of roughly $1 million in salaries and benefits each year.[4]

CURRENT PATIENT MATCHING SOLUTIONS

Unique Patient Identifier (UPI)

The idea behind a UPI is to provide a mechanism across all health care providers to identify individual patients. Much like a Social Security number, the unique number would correlate only to the patient to whom it is assigned, associating this code with the patient anywhere within the national health care system. Creating a unique number or code for each individual patient would ensure that information could be passed across care settings without being mistakenly incorporated into another patient's record.

Proponents of UPIs believe that adopting a discrete identifier is the most efficient way to facilitate sharing information and protects against flaws found in data algorithms and other matching approaches. UPIs would also guard against entering duplicate data and avoid the use of Social Security numbers as part of a patient's file.

Opponents believe that the use of UPIs would increase security and privacy risks. Data security lapses are common in health care settings, and many patient groups believe that UPIs would facilitate theft or disclosure of private health information. In particular, many are concerned that a government-created UPI would be linked to other federal or state records, such as law enforcement or financial files, which could result in the disclosure of even more sensitive information if stolen. Another concern is that the creation of a UPI system will be a costly and expansive task, requiring both new infrastructure and technology updates to accommodate a new system of patient identification. The RAND Corporation estimates that this expense could range from $3.9 to $9.2 billion.[5]

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes a provision to develop a UPI system.[6] This section of the law, however, was never implemented due to concerns over patient privacy. Since that time, Congress has effectively stopped efforts to develop a UPI by blocking federal funding of such a system. Lawmakers have included prohibition language in appropriation bills each year to prevent any federal dollars from supporting the creation of a UPI.

Biometrics

Biometric identifiers, including voice patterns, fingerprints, iris patterns, facial shapes, and vein patterns, are another method of uniquely identifying individuals. The advantage of biometric identifiers is that they are highly specific to an individual and identity can be verified without resorting to documents or cards that may be lost or stolen. Disadvantages of biometric identifiers include the expensive cost of using these identifiers and privacy concerns. Many patients may be even less comfortable with recording biometric data than with using a UPI. In addition, attempts to correctly match records in a patient's absence may prove complicated.

Data Algorithms

The most common patient matching solution today involves data algorithms. The health care industry has implemented two primary matching methods: deterministic and probabilistic algorithms. Deterministic matching performs a character-by-character match on a specified set of data attributes. Probabilistic algorithms use statistical analysis of a set or string of patient data attributes that, when considered in concert, determine whether there is an automatic match, no match, or manual review. The two methods can be used alone or together.[7]

Most health care entities try to match records by identifying and matching specific data elements. Stakeholders note that matching using demographic attributes requires the use of data that is unlikely to change; however, they disagree on which data attributes are stable across time. The three most common attributes used for matching are a patient's name, date of birth, and gender; however, problems can arise when patients change their name, use nicknames, or these data are not unique. Another concern is that the format of the data attributes often varies, sometimes within the organization itself. For example, a patient's date of birth may be formatted as December 9, 1982 or 12/9/82.

Due to this variability, the industry has not settled on a standard matching method or algorithm to perform patient matching. Rather, different health care systems and entities perform matching using various methods. Patient matching success rates therefore vary across the industry, resulting in an increase in the rate of false positives or mismatched records when trying to coordinate care across different settings. Most stakeholders estimate that an 80 percent match rate is considered fairly successful for a health care institution.

ADVOCACY ON PATIENT MATCHING

Given the impact on interoperability, patient safety, and coordinated care, there is widespread industry agreement that maintaining the status quo associated with patient matching is not an acceptable option. Accordingly, numerous stakeholders are working to find patient matching solutions and offer recommendations. The following outlines ongoing advocacy in this area.

The Patient Identification and Matching Initiative, sponsored by the Office of the National Coordinator for Health Information Technology (ONC)

ONC's effort is focused on identifying incremental steps to help ensure the accuracy of every patient's identity and the availability of their information wherever and whenever care is needed. Based on interviews and a comprehensive review of current matching solutions, ONC published the following findings to improve patient matching:

1. Standardized patient identifying attributes should be required in the relevant exchange transactions.
2. Any changes to patient data attributes in exchange transactions should be coordinated with organizations working on parallel efforts to standardize healthcare transactions.
3. Certification criteria should be introduced that require certified EHR technology (CEHRT) to capture the data attributes that would be required in the standardized patient identifying attributes.
4. The ability of additional, non-traditional data attributes to improve patient matching should be studied.
5. Certification criteria should not be created for patient matching algorithms or require organizations to utilize a specific type of algorithm.
6. Certification criteria that requires CEHRT that performs patient matching to demonstrate the ability to generate and provide to end users reports that detail potential duplicate patient records should be considered.

7. Build on the initial best practices that emerged during the environmental scan by convening industry stakeholders to consider a more formal structure for establishing best practices for the matching process and data governance.
8. Work with the industry to develop best practices and policies to encourage consumers to keep their information current and accurate.
9. Work with healthcare professional associations and the Safety Assurance Factors for HER Resilience (SAFER) Guide initiative to develop and disseminate educational and training materials detailing best practices for accurately capturing and consistently verifying patient data attributes.
10. Continue collaborating with federal agencies and the industry on improving patient identification and matching processes.[8]

The Sequoia Project

In November of 2015, the Sequoia Project, a non-profit organization focused on improving interoperability, partnered with several large care institutions to release a cross-organizational framework for patient identity management.[9] The AMA is a founding member of the Sequoia Project. The framework suggests minimal acceptable patient matching rules, provides a case study, and outlines a maturity model to improve patient matching in the future. Key findings from the framework include:

- The biggest opportunity to immediately impact matching rates is standardized formats for demographic data among data sharing participants;
- Consistent name representation will be a challenge without probabilistic assistance because of data collection workflow issues that favor alternate representations (such as preferred name over legal name); and
- Acceptable patient matching data integrity (99.99 percent) may require a supplemental identifier in addition to the required fields. This allows for probabilistic linking where alternative representations are allowed among the exchange participants and where established linkages are expected to be reusable for future exchange transactions.

The framework was open for public comment and will be further revised in the future.

Healthcare Information and Management Systems Society (HIMSS)

HIMSS is a non-profit organization focused on improving health care through technology. Its membership includes a broad sector of health care stakeholders and executives, including vendors, providers, and technology experts. In 2011, HIMSS developed the Patient Identity Integrity Toolkit to disseminate best practices and processes for matching patient records.[10] Within the toolkit, HIMSS developed a set of key performance indicators (KPIs) that allow an organization to evaluate its patient matching processes and technology and make continuous improvements. The toolkit provides both the list of data attributes to be collected and the formulas used to calculate each performance indicator. In addition, HIMSS has recently partnered with ONC through the agency's Patient Data Matching Initiative to conduct tests to improve patient matching algorithms and identify the common attributes that achieve high positive match rates across disparate systems.[11]

The College for Healthcare Information Management Executives (CHIME)

As the leading association for Chief Information Officers (CIOs) and senior health IT leaders, CHIME has launched a $1 million competition aimed at finding 100 percent accuracy in identifying patients across the United States. The competition asks that proposed patient matching efforts include methods to protect patient privacy and work across the vast majority of providers, insurers, and other stakeholders. The top 10 solutions will have an opportunity to demonstrate their prototypes and will be judged by a variety of stakeholders.[12]

Global Patient Identifiers Inc. (GPII)

GPII is working to establish a voluntary system that would allow patients or other health care stakeholders to request a unique identifier. Unlike a UPI, a voluntary identifier could be administered by a nonprofit group or public-private partnership thus mitigating some of the concerns related to a federally sponsored UPI. The voluntary identifier would allow patients to make individual privacy decisions regarding the sharing of their data and other information.[13]

CommonWell Health Alliance

Launched in March 2013, the CommonWell Health Alliance has prioritized patient linking and matching solutions. Specifically, it supports patient matching by explicit patient identifier, key patient demographic data, or clinical data. CommonWell utilizes the services of RelayHealth as a third-party patient identification and linking system to support the exchange of health data along the care continuum. Over time, the patient linking and matching solution should track and normalize a patient's identity across care settings regardless of the native patient indexing system.[14]

National Strategy for Trusted Identities in Cyberspace (NSTIC)

NSTIC is a White House initiative to work collaboratively with the private sector, advocacy groups, public sector agencies, and other organizations to improve the privacy, security, and convenience of online transactions. While not limited to health care, NSTIC has focused on creating an "Identity Ecosystem" that establishes standards to authenticate digital identities. NSTIC has outlined the following four guiding principles for this Identity Ecosystem:

1 Identity solutions will be privacy-enhancing and voluntary;
2 Identity solutions will be secure and resilient;
3 Identity solutions will be interoperable; and
4 Identity solutions will be cost-effective and easy to use.

In 2013, NSTIC launched a number of pilots, which included credentials for health care.[15]

AMA POLICY

AMA Policies D-315.996, H-190.961, and D-190.989 focus mainly on a federally mandated patient identifier and essentially seek to block the creation of such a system. These policies, however, fail to more broadly address other patient matching solutions and the need to identify ways to improve interoperability and care coordination. They also do not address the difference between a mandatory vs. voluntary patient identifier, which, if created by a non-governmental entity, may pose fewer privacy concerns.

In contrast, AMA Policy D-315.981, adopted at the 2010 House of Delegates Annual Meeting, more broadly addresses patient matching problems. It asks that our AMA work with stakeholders to develop a strategy for patient identification at the national level, addressing the need to find a solution to this problem that works across all health care settings. This policy also acknowledges the many different alternatives that either exist or may be discovered that could resolve current matching problems. A full listing of relevant AMA Policy on patient matching is included in the appendix to this report.

CONCLUSION

Work on patient identity and matching has accelerated in the past few years, with various stakeholders seeking to develop a better understanding of the root problems and identifying solutions. Much of this work has demonstrated that there is no answer at this time that will ensure patients' health information is accurately matched all of the time. Stakeholders are therefore engaging in a national dialogue on how to move forward with efforts to improve patient identification.

Consequently, current AMA policy on this issue is up to date as it allows our AMA to engage and discuss alternatives to improve patient matching. It encourages our AMA to engage with various stakeholders to find a meaningful solution, including a national strategy that would work across all care settings. Furthermore, it does not limit our AMA to only considering a patient identifier but would allow our AMA to consider alternatives or the use of an identifier as part of a comprehensive strategy to improve patient matching. While there may come a time where privacy and security have improved to support use of a federal patient identifier, there are still existing concerns in implementing this approach. Current AMA policy D-315.981, however, allows our AMA to continue to consider the benefits of a voluntary identification system and support newly emerging patient matching solutions. Given the importance of this issue for interoperability and developing new alternative payment and delivery models, our AMA should use this existing policy to become a leader in this space.

APPENDIX - Current AMA Policy

D-315.981 National Master Patient Identifier
Our AMA, along with other stakeholders, will work with the Office of the National Coordinator for Health Information Technology to develop a strategy for patient identification system at the national level.(BOT Rep. 23, A-10)

D-315.996 Interim Report of the Inter-Council Task Force on Privacy and Confidentiality
Our AMA: (1) strongly supports the voluntary adherence of all Institutional Review Boards (IRBs) to the standards of the Common Rule (45 CFS 46), regardless of whether or not the institution receives federal funding; (2) will continue to advocate aggressively for prohibitions on the sale and exchange of personally identifiable health information for commercial purposes in the absence of explicit authorization from the patient; (3) will continue to advocate for federal preemption that establishes a 'floor' in legislation on patient privacy and confidentiality, rather than a 'ceiling,' subject to review if the AMA is satisfied that adequate patient safeguards are assured by specific proposed legislation; (4) to facilitate research done with subjects from more than one state while continuing to protect patients, our AMA should develop model state legislation on privacy and confidentiality; (5) will advocate for legislative action to repeal the pertinent section of the "Health Insurance Portability and Accountability Act of 1996" that mandates the establishment of a Unique Patient Identifier; and (6) Inter-council Task Force on Patient Privacy and Confidentiality continue to address unresolved issues relating to patient privacy and confidentiality with particular attention to public health and epidemiology issues and requirements, and report its recommendations at I-99(BOT Rep. 36, A-99; Reaffirmed: CEJA Rep. 8, A-09)

H-190.961 Repeal of Federally Mandated Uniform Medical Identifiers
Our AMA: (1) actively supports legislation that would repeal the unique patient medical health identifier mandated by the Health Insurance Portability and Accountability Act of 1996; and (2) urges all state medical societies to ask each of their congressional delegations to declare themselves publicly on this matter.(Res. 207, I-01; Reaffirmed: BOT Rep. 22, A-11)

D-190.989 HIPAA Law And Regulations
(1) Our AMA shall continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care. (2) If satisfactory modification to the HIPAA Privacy Rule is not obtained, our AMA shall aggressively pursue appropriate legislative and/or legal relief to prevent implementation of the HIPAA Privacy Rule. (3) Our AMA shall continue to oppose the creation or use of any unique patient identification number, including the Social Security number, as it might permit unfettered access by governmental agencies or other entities to confidential patient information. (4) Our AMA shall immediately begin working with the appropriate parties and trade groups to explore ways to help offset the costs of implementing the changes required by the Health Insurance Portability and Accountability Act so as to reduce the fiscal burden on physicians.(Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)

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15. DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

At the American Medical Association's (AMA) 2007 Annual Meeting, Policy G-600.135 (see Appendix A for policies cited in report) was adopted, establishing a mechanism by which specialty society representation in the House of Delegates (HOD) would be determined. The mechanism for specialty society delegate allocation is based on a formula that looks at a society's AMA membership and the number of ballots cast for representation in each specialty (the specialty ballot is available online at www.ama-assn.org/go/ballot). The goal was to determine appropriate allocation of specialty society delegates.

At the AMA's 2012 Annual Meeting, BOT Report 11-A-12 presented an update on the ballot process and the following recommendation was adopted as Policy G-600.021[4]:

> The Board of Trustees recommends that the current ballot system remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

In response to the 2012 report, at the 2013 Interim Meeting, BOT Report 4-I-13 recommended that the current specialty delegation allocation system (ballot and formula) be discontinued and that specialty society delegate allocation in the HOD be determined in the same manner as state medical association delegate allocation, using the number of AMA members in each society to apportion delegates at the usual rate of one delegate per 1,000 AMA members or fraction thereof. The report was amended by the HOD to call for further study and report back at A-16 (see Policy G-600.023). Current practice bases delegate apportionment for each specialty society on the number of members who have designated that society for representation and weighting those ballots using a formula developed in BOT Report 17-A-07. The number of designations each specialty society has obtained is adjusted annually based on targeted levels of participation by AMA members. Delegates are then apportioned by applying the one per 1,000 rate to the weighted figure (see Appendix B for the formula used).

BACKGROUND

The allocation of delegates for both the state medical associations and the specialty societies, based on the same numbers (one delegate per 1,000 AMA members or fraction thereof) has always been the standard, but determining a mechanism to apportion specialty delegates has remained a challenge.

While it is a straightforward proposition to count the AMA members in a state using data on dues payments or members' addresses, enumerating individual members in specialty societies is considerably more difficult, because common data elements (other than name) in membership files of the AMA and most specialty societies are limited, which makes matching a complicated and time consuming process. In addition, an individual can belong to multiple specialty societies. Thus, when proportional representation for specialty societies was adopted in 1996, AMA members were to select, using a ballot, a specialty society to represent their interests in the HOD.

The number of delegates to which a specialty society is entitled depends on the number of AMA members who have designated that society for representation. In BOT Report 17-A-07, the Board anticipated that by 2012, at least 80 percent of eligible AMA members would have designated a specialty society for representation (eligible members are those beyond their third year of medical school). Unfortunately, the designation (i.e., balloting) process has never functioned as well as planned. In 2007, when the report was adopted, approximately 40 percent of members had cast ballots. Despite many efforts to increase the number of ballots cast, the number has not increased. In fact, as

of the end of 2015 the proportion of AMA members who have designated any specialty society for representation is 28 percent.

SPECIALTY DELEGATE ALLOCATION

The number of delegates for each specialty society is determined by a balloting process as described in G-600.021 and policy G-600.135 subject to a cap based on the number of AMA members in the society. Previously, it was suggested that the five-year review and delegate allocation processes be tied together to create one process that would streamline the two activities. The five-year review is the process which determines if a society that has been admitted to the HOD continues to meet the requirements for representation in the HOD. One of the requirements is the submission of membership data. The data are used to determine a specialty society's eligibility to be seated in the House; they are not currently used to determine delegate allocation directly. Under the proposed process, each specialty society that currently has one delegate or a membership of less than 1,001 AMA members would continue to be allocated one delegate. It is important to note, the majority of specialty societies (72) have less than 1,001 AMA members. Those specialty societies with 1,001 or more members looking to maintain or gain more than one delegate would need to submit membership data annually to determine their delegate allocation. Specialty societies that are in good standing according to the five-year review will be automatically allocated one delegate without the submission of membership data annually.

Careful consideration was given to the points raised at I-13 including those related to members who are members of multiple specialty societies. Data was collected to determine the overlap in membership and the scope of the issue. Every specialty society seated in the HOD in 2014 was asked to submit a file of their membership so that the AMA could analyze all of the memberships that were held. In 2015, the request was repeated to those specialties that had more than one delegate seated in the HOD to determine consistency. The data from both years showed a very similar trend in overlapping memberships. 20 percent of specialty society members who are members of the AMA are members of at least two specialty societies. Another 10 percent are members of three to four specialty societies. The highest number of memberships was 11 specialties by one member.

With this data in mind, your Board of Trustees is recommending a system that will not tax the resources of specialty societies by asking for a data file from every society every year, but will fairly allocate specialty society delegates in the HOD. Realizing that overlapping membership should be recognized and not penalized while at the same time maintaining the democracy of the HOD and the principle of one delegate one vote is a crucial element to the delegate allocation system. The most common tendency was to be a member of two specialties and so as to not discount the other membership a factor of 25 percent was agreed upon as the modifying factor to compensate for duplicate memberships.

This figure was derived from data collected in preparing this report. Data for the 2014 membership year were collected from all 118 specialty societies then seated in the HOD, and the average number of specialty society memberships was 1.28, which would suggest a reduction factor of about .22 (22.14%). For the 2015 membership year, data were collected only from the 20 largest specialty societies, for which the average number of memberships was 1.54 with a corresponding reduction factor of .351. These reduction factors are simply the reciprocals of the average number of memberships, and applying them to a society offsets the effect of duplicate memberships. The weighted average of these numbers is .243, which has been rounded up to .25 or 25 percent.

The Board of Trustees believes the system outlined in the recommendations of this report will streamline the allocation process, allow representation of the specialty societies that is equitable, eliminate the ballot system which has never worked the way it was designed, and will not alter the size of the HOD in a significant way.

Implementation of this system will only slightly impact the overall size of the HOD. If the ballot system and the formula that is currently in place to make up for the lack of ballots cast were to be replaced with this proposal and membership trends remain as they are currently, there could be approximately four additional specialty delegates using latest available data (either 2014 or 2015, Appendix C). The vast majority of specialty society delegations would be unchanged (87 delegations would remain the same size) or see a small increase in delegates (16 delegations would increase by one delegate and two delegations would gain two delegates). At the same time, eight societies would see their delegation downsized by one delegate and three societies would lose two delegates. The greatest impact would be seen by a single society that would potentially lose five delegates and two others that could gain as many as four delegates. These are only estimates, as actual numbers will depend on 2016 membership data

from the specialty organizations. The Board recognizes that downsizing a delegation can be painful and therefore recommends a transition period to allow the societies to attempt to improve membership and to implement the new allocation.

While AMA membership as a whole has increased over the past few years, some states and specialties have experienced membership declines. The bylaws (§ 2.1.1.1.1) allow states a one year grace period to correct a membership decline that would otherwise result in the loss of a delegate (states must submit a plan to increase membership to qualify for the grace period). A similar provision should apply to specialty societies.

CONCLUSION

Equitable allocation of the delegates to specialty societies based upon the principle of one delegate for every 1,000 AMA members has been a challenge. The ballot system although well intentioned has not achieved this goal. Maintaining a fair balance between states and specialties is key, but many physicians belong to more than one specialty society. The allocation of every AMA member to every specialty society to which they belong is not currently possible. Your Board of Trustees recommends a straightforward allocation of specialty society delegates based upon AMA membership with a modifier derived from analyzed data to adjust for multiple memberships. Hoping to simplify the process for the majority of specialty societies the allocation will use data collected as part of the five-year review for those societies with only a single delegate; while allowing societies that seek more than one delegate to submit annual membership data. The overall impact to the size of the HOD will be minor, but we recognize that change for individual delegations can be difficult and believe a transition period is appropriate. In addition, specialty societies that suffer membership declines should have the same opportunity as state societies for recovery.

RECOMMENDATIONS

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

1. That the current specialty society delegation allocation system (ballot and formula) be discontinued and that specialty society delegate allocation in the House of Delegates be determined based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof, reduced by a factor of 25% to reflect multiple memberships, starting with the 2017 delegate apportionment.

2. That specialty societies that are in good standing according to the five-year review will continue to be allocated automatically at least one delegate without the submission of membership data annually. Specialty societies with more than one delegate or those seeking to obtain an additional delegate must submit membership data annually to determine delegate allocation.

3. That a transition period be established to allow specialty societies that would lose delegates with the new allocation system a one year grace period to increase membership and if necessary to downsize their delegation. Any society that would lose more than two delegates with the new allocation system would be allowed an extended grace period and required to downsize only one delegate per year for the next five years.

4. That after 2017 specialty societies that would lose delegate(s) based on declining membership be allowed a one-year grace period to increase their AMA membership and that their delegation remain unchanged until the end of the grace period provided that they provide the AMA a specific plan to attempt to increase AMA membership within their specialty society.

5. That the Council on Constitution and Bylaws investigate the need to amend any policy or bylaws.

Appendix A - Bylaws and Policy

Retention of Delegate, B-2.1.1.1.1
If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

G-600.021 Specialty Society Representation in our AMA House
The number of AMA delegate positions allocated to the specialty societies in our AMA/Federation House will be determined in the following manner: (1) The number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 1,000 AMA members, or portion of 1,000 AMA members, who select that a particular specialty society on the annual ballot and return the ballot to our AMA; and (2) Each specialty society that meets the eligibility criteria and is represented in our AMA/Federation House will be assured of at least one delegate and alternate delegate position regardless of the number of AMA members who select the society on the ballot and return the ballot to the AMA. (3) Our AMA will: (a) continue to include the ballot postcard in the Member Welcome Kit; (b) continue to promote the online ballot application to increase specialty society designations; (c) work with all willing specialty societies to solicit additional specialty society designations, using both printed ballots and electronic communications vehicles; and (d) continue to send email ballot solicitations to members who have not yet cast a ballot. (4) The current ballot system will remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

G-600.023 Designation of Specialty Societies for Representation in the House of Delegates
1. Specialty society delegate allocation in the House of Delegates shall be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof. 2. Specialty society membership data shall be submitted annually by all societies with more than one delegate or societies seeking to obtain an additional delegate or delegates as part of a two-year pilot program with a report back at the 2016 Annual Meeting of our AMA House of Delegates. 3. The current specialty delegation allocation system (ballot and formula) will be continued until the pilot program is completed and the 2016 Annual Meeting report is acted upon by the House of Delegates. 4. This system shall be tested with all specialty societies with more than one delegate seated in the House of Delegates. 5. Organizations that would lose or gain one or more delegates through this pilot delegate allocation system shall assist our AMA with documenting the impact. However, no actual changes to delegation allocation other than those which occur through the five-year review and balloting system will be implemented until the data are collected and presented for acceptance to our AMA House of Delegates at the 2016 Annual Meeting. 6. In the future, any system of delegate allocation will continue to be monitored and evaluated for improvements.

G-600.135 Specialty Society Delegate Representation in the House of Delegates
1. Our AMA will continue efforts to expand awareness and use of the designation mechanism for specialty society representation, working wherever possible with relevant members of the Federation. 2. The system of apportioning delegates to specialty societies be enhanced by a systematic allocation of delegates to specialty societies by extrapolating from the current process in which members designate a specialty society for representation. The recommended model will: (a) establish annual targets for the overall proportion of AMA members from whom designations should have been received; (b) adjust actual designations by increasing them proportionately to achieve the overall target level of designations; (c) limit the number of delegates a society can acquire to the number that would be obtained if all the society's AMA members designated it for representation; (d) be initiated with delegate allocations for 2008, following the expiration of the freeze, which ends December 31, 2007; and (e) be implemented over five years because this will result in the least disruption to the House of Delegates and allow the process to unfold naturally. 3. The Board of Trustees will prepare annual reports to the House describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations, and recommending changes in strategies that might be required to implement existing policy on representation of specialty societies. In addition, the Board should, in these or other reports: (a) develop a system for use among direct members to solicit their designations of specialty societies for representation, with an eye on how that system might be expanded or adapted for use among other members; and (b) engage in discussions with specialty societies that will lead to enhanced data sharing so that delegate allocations for both state and specialty societies can be handled in parallel fashion. 4. Our AMA will include in the specialty designation system an option to permit those members who wish to opt out of representation by a specialty society to do so when any automatic allocation system is used to provide representation for specialty societies that are represented in the House of Delegates. 5. If any specialty society loses delegates as a result of the apportionment process, the specialty society shall have a one-year grace period commencing January 1, 2008. At the expiration of this one-year grace period, a phase-in period shall be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented. 6. AMA Bylaw 2.11111 grants state societies a one-year grace period following the freeze expiring December 31, 2007 (per Bylaw 2.121). At the end of the grace period, a phase-in period will be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented.

Appendix B - 2016 Apportionment of Specialty Society Delegates

Board of Trustees Report 17-A-07 implemented the current mechanism for apportioning delegates to specialty societies in the House of Delegates.

The starting point for societies is the number of ballots submitted by AMA members designating a particular specialty society to represent their interests in the House of Delegates. That number is weighted, using the formula developed in BOT Report 17-A-

07, and the resulting figure apportions delegates at the rate of one per 1,000 or fraction thereof, subject to a cap based on the number of AMA members in the society.

The weighting factor is directly related to the total AMA membership and inversely related to the proportion of AMA members who have actually designated a society for representation purposes. That is, as AMA membership increases, the weight increases, and as the proportion of members casting a ballot increases, the weight decreases. The weight is limited to 80% of its calculated value, and the same weight applies to every specialty society.

Elements of the formula are (with their 2016 values):

a. Members eligible to ballot, 4th year student or beyond (198,408)
b. Actual ballots (54,571, which includes 447 who chose NOT to designate a specialty society)
c. a/b (54,971/198,408 = 0.27504)
d. 1/c (1 / 0.27504 = 3.635777)
e. d * 0.8 (3.635777 * 0.8 = 2.908622)
f. e * ballots / 1000, with result rounded up to next whole number

The delegate apportionment is subject to the following constraints:

1. Every specialty society seated in the House of Delegates has at least one delegate;
2. The number of delegates cannot exceed the figure that would apply if ALL its AMA members selected that society for representation purposes.

The following example illustrates use of the formula. If at year end 2015 a society had 1,015 ballots and 7,913 AMA members:

1015 * 2.909 / 1000 ➔ 2952.6 / 1000 ➔ 2.9 ➔ rounds up to 3; but if all 7913 AMA members had designated the society, the cap would be 8 delegates (7913 / 1000 = 7.9 ➔ rounds up to 8). The society gets the lesser of the calculated number or the cap, or in this case 3 delegates.

Appendix C

This table shows the AMA membership for each specialty society from 2014, the year we collected data from every specialty society seated in the House. In 2015, we collected data from a select number of societies and that number is reflected here as well. The final column is an estimation of what the delegate would look like if the process proposed in this report were adopted and the latest available membership number was reduced by 25 percent to determine the delegate allocation.

	Latest Membership Data (2014 or 2015)	2016 Delegates	Delegates using 25% reduction in membership
Academy of Physicians in Clinical Research	145	1	1
Aerospace Medical Association	181	1	1
AMDA - The Society for Post-Acute and Long Term Care Medicine	928	1	1
American Academy of Allergy, Asthma and Immunology	380	1	1
American Academy of Child and Adolescent Psychiatry	1,524	1	2
American Academy of Cosmetic Surgery	375	1	1
American Academy of Dermatology	2,955	4	3
American Academy of Disability Evaluating Physicians	250	1	1
American Academy of Facial Plastic and Reconstructive Surgery	372	1	1
American Academy of Family Physicians	17,323	18	13
American Academy of Hospice and Palliative Medicine	810	1	1
American Academy of Insurance Medicine	68	1	1
American Academy of Neurology	2,207	3	2
American Academy of Ophthalmology	3,380	4	3
American Academy of Orthopaedic Surgeons	6,755	5	6

	Latest Membership Data (2014 or 2015)	2016 Delegates	Delegates using 25% reduction in membership
American Academy of Otolaryngic Allergy Inc.	349	1	1
American Academy of Otolaryngology-Head and Neck Surgery	2,895	3	3
American Academy of Pain Medicine	494	1	1
American Academy of Pediatrics	8,160	7	7
American Academy of Physical Medicine and Rehabilitation	1,452	2	2
American Academy of Psychiatry and the Law	355	1	1
American Academy of Sleep Medicine	1,280	1	1
American Association for Geriatric Psychiatry	876	1	1
American Association for Hand Surgery	275	1	1
American Association for Thoracic Surgery	281	1	1
American Association of Clinical Endocrinologists	872	1	1
American Association of Clinical Urologists,	1,047	1	1
American Association of Gynecologic Laparoscopists	1,590	1	2
American Association of Hip and Knee Surgeons	396	1	1
American Association of Neurological Surgeons	952	2	1
American Association of Neuromuscular & Electrodiagnostic Medicine	830	1	1
American Association of Plastic Surgeons	190	1	1
American Association of Public Health Physicians	48	1	1
American Clinical Neurophysiology Society	202	1	1
American College of Allergy, Asthma and Immunology	591	1	1
American College of Cardiology	5,693	4	5
American College of Chest Physicians	2,552	1	2
American College of Emergency Physicians	6,705	5	6
American College of Gastroenterology	1,360	2	2
American College of Legal Medicine	176	1	1
American College of Medical Genetics and Genomics	370	1	1
American College of Medical Quality	126	1	1
American College of Mohs Surgery	310	1	1
American College of Nuclear Medicine	88	1	1
American College of Occupational and Environmental Medicine	561	1	1
American College of Phlebology	352	1	1
American College of Physicians	22,690	13	17
American College of Preventive Medicine	590	1	1
American College of Radiation Oncology	325	1	1
American College of Radiology	6,077	7	5
American College of Rheumatology	1,095	2	1
American College of Surgeons	12,445	6	10
American Congress of Obstetricians and Gynecologists	12,000	12	9
American Gastroenterological Association	1,879	1	2
American Geriatrics Society	857	1	1

	Latest Membership Data (2014 or 2015)	2016 Delegates	Delegates using 25% reduction in membership
American Institute of Ultrasound in Medicine	1,238	1	1
American Medical Group Association	3,041	1	3
American Orthopaedic Association	422	1	1
American Orthopaedic Foot and Ankle Society	265	1	1
American Psychiatric Association	7,478	8	6
American Roentgen Ray Society	2,283	1	2
American Society for Aesthetic Plastic Surgery, Inc.	348	1	1
American Society for Clinical Pathology	2,317	1	2
American Society for Dermatologic Surgery	1,029	1	1
American Society for Gastrointestinal Endoscopy	1,761	1	2
American Society for Metabolic and Bariatric Surgery	313	1	1
American Society for Radiation Oncology	858	1	1
American Society for Reproductive Medicine	868	1	1
American Society for Surgery of the Hand	684	1	1
American Society of Breast Surgeons	568	1	1
American Society of Addiction Medicine	627	1	1
American Society of Anesthesiologists	6,146	7	5
American Society of Bariatric Physicians	263	1	1
American Society of Cataract and Refractive Surgery	1,197	1	1
American Society of Clinical Oncology	3,227	2	3
American Society of Colon and Rectal Surgeons	241	1	1
American Society of Cytopathology	238	1	1
American Society of Echocardiography	1,135	1	1
American Society of General Surgeons	366	1	1
American Society of Hematology	974	1	1
American Society of Interventional Pain Physicians	567	1	1
American Society of Maxillofacial Surgeons	87	1	1
American Society of Neuroimaging	101	1	1
American Society of Neuroradiology	532	1	1
American Society of Ophthalmic Plastic and Reconstructive Surgery	165	1	1
American Society of Plastic Surgeons	919	2	1
American Society of Retina Specialists	582	1	1
American Thoracic Society	1,393	1	2
American Urological Association	1,181	2	1
Association of Military Surgeons of the United States	704	1	1
Association of University Radiologists	197	1	1
College of American Pathologists	3,294	4	3
Congress of Neurological Surgeons	1,027	1	1
Contact Lens Association of Ophthalmologists, Inc.	38	1	1
The Endocrine Society	1,134	1	1

	Latest Membership Data (2014 or 2015)	2016 Delegates	Delegates using 25% reduction in membership
Heart Rhythm Society	532	1	1
Infectious Diseases Society of America	1,245	1	1
International College of Surgeons - US Section	329	1	1
International Society of Hair Restoration Surgery	90	1	1
International Spine Intervention Society	588	1	1
National Association of Medical Examiners	120	1	1
North American Spine Society	1,448	1	2
Obesity Medical Association	267	1	1
Radiological Society of North America	2,697	1	3
Renal Physicians Association	597	1	1
Society for Cardiovascular Angiography and Interventions	462	1	1
Society for Investigative Dermatology, Inc.	219	1	1
Society for Vascular Surgery	789	1	1
Society of American Gastrointestinal Endoscopic Surgeons	1,172	1	1
Society of Critical Care Medicine	961	1	1
Society of Hospital Medicine	1,804	1	2
Society of Interventional Radiology	644	1	1
Society of Laproendoscopic Surgeons	1,045	1	1
Society of Nuclear Medicine and Molecular Imaging	543	1	1
Society of Thoracic Surgeons	1,192	2	1
The Triological Society	404	1	1
Undersea and Hyperbaric Medical Society	193	1	1
United States and Canadian Academy of Pathology, Inc.	1,430	1	2
Total	–	220	225

16. CREATION OF THE AMA SUPER PAC (RESOLUTION 606-I-14)

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

BACKGROUND

Resolution 606-I-14, introduced by the Georgia Delegation, called upon our AMA to create and provide significant initial and ongoing funding for an AMA "super" political action committee (super PAC) to make independent expenditures for or against candidates for federal office based on recommendations from state medical society PACs and support from the American Medical Association Political Action Committee (AMPAC). The resolution called for the AMA Board of Trustees to provide an annual contribution to the super PAC and identified AMA corporate reserves as a potential source of funding for this effort. The resolution also called for the creation of a governing board of directors for the super PAC to be responsible for the allocation of independent expenditure monies and development of a plan to encourage contributions from other entities eligible to contribute under federal election law. The reference committee report noted that the proposal raised several complicated issues that warranted

thorough analysis. The resolution was referred to the Board of Trustees with instructions to report back at the 2015 Annual Meeting.

Board of Trustees Report 18-A-15 provided general background information on the growth of and funding sources for federal super PACs, common characteristics of these organizations, and identified benefits and risks associated with the creation of a super PAC for the AMA. The report noted on the positive side that organized medicine needs more champions in Congress and a super PAC would be an extra advocacy tool to potentially help elect our preferred candidates in federal elections. However, a substantial 35 percent federal excise tax would be imposed on expenditures of AMA corporate funds used to fund an AMA super PAC, and there is no evidence that the AMA would be able to raise sufficient funds from outside sources, including physicians who are not members of the AMA. The report concluded that AMA corporate funds should not be used for this purpose and that the Board of Trustees would continue to study the feasibility of creating a super PAC, with emphasis on exploring sources of sufficient outside funding and assuring that AMPAC's ongoing activities and fundraising would not be negatively affected. The report was referred back to the Board of Trustees for further study.

DISCUSSION

To further assess the advantages and disadvantages of an AMA super PAC, and the availability of outside funding, the AMA retained the services of Jan Witold Baran, JD, of the law firm Wiley Rein LLP to provide a review of the practical and legal issues the AMA should consider before forming a super PAC. The AMA also engaged a leading research firm, Public Opinion Strategies, to survey physician attitudes about funding an AMA-established super PAC.

Mr. Baran is a pre-eminent federal election law expert who advises clients, including trade associations, on campaign financing and other election law matters. Mr. Baran has represented clients before the US Supreme Court, federal lower courts, the Federal Election Commission, and the ethics committees of Congress. His Supreme Court cases include *Citizens United v. Federal Election Commission* in which he represented the US Chamber of Commerce (as *amicus curiae*). The Court's decision in that case resulted in the dramatic rise of super PACs by allowing corporations and unions to spend unlimited amounts of money on political activities, such as advertising, so long as expenditures are made independently of political parties and candidates. Mr. Baran is the author of *The Election Law Primer for Corporations* published by the American Bar Association. Mr. Baran was assisted in his review on behalf of the AMA by Eric Wang, JD, special counsel at Wiley Rein, who previously served as legal counsel for Americans for Prosperity, one of the largest super PACs in the country.

Mr. Baran has noted that very few trade associations or professional groups have launched a super PAC. Mr. Baran recommends that in determining whether to form a super PAC, the AMA should consider what its objectives are, whether a super PAC is likely to achieve those objectives, and whether a super PAC is likely to raise sufficient funds to influence election outcomes. Mr. Baran advises that super PAC donors tend to be very high net worth individuals, often from the financial sector and large business owners, and unions. Most super PACs are highly partisan, often focused on a single issue, or created to benefit a single candidate. Mr. Baran has noted also that super PACs have had a mixed record of effectiveness at achieving their goals, despite expenditures of substantial sums on political advertising. Many people have a negative view of super PACs which could have an impact on how AMA members, non-member physicians and the public view the AMA if it establishes a super PAC. Mr. Baran cautioned that the AMA should carefully consider whether efforts to promote a super PAC would adversely affect AMPAC's fundraising and activities. Importantly, a significant tax burden would be imposed on the AMA if corporate funds (including reserves) were used to support a super PAC. In summary, Mr. Baran pointed out that the precedent for professional associations establishing a super PAC funded by individual or corporate contributions having a meaningful impact on federal elections appears to be non-existent.

To assess physician support for the creation of an AMA super PAC, the AMA engaged Public Opinion Strategies, one of the country's leading public opinion research firms specializing in political, public affairs, public policy, and corporate positioning research. They conducted a national online survey of 500 AMA member and non-member physicians in January 2016 using the M3 Global Research opted-in panel of US physicians. The survey data suggests that even though the physicians surveyed expressed a high level of interest in the 2016 elections, there is little support for the AMA to establish a super PAC:

- More than four in ten physician respondents (43%) say they will not donate any money to political action committees, political parties, independent expenditure organizations, or candidates running for office in 2016.
- Another 34% indicated they are likely to donate less than $500 to PACs, parties, independent expenditure organizations, or candidates in 2016.
- When asked if they would consider donating to an AMA super PAC, 87% said they would not be likely to donate to the super PAC.
- AMA members indicated they would be more likely to consider donating to an AMA super PAC (34%) than non-AMA members (5%).
- Of the 65 physicians in the survey who said they would consider donating to an AMA super PAC, the reported level of a donation is extremely low. Only two physicians in the survey said they were willing to donate between $5,000 and $9,999, and none were willing to donate $10,000 or more to an AMA super PAC.
- Respondents who do not favor an AMA super PAC indicated they were concerned the super PAC might support candidates they do not support personally, they do not agree with the concept of super PACs, they are not politically inclined or generally do not make political donations, or their political views do not align with the political activities of the AMA.

The results of the survey indicate there is little to no interest by either AMA member or non-member physicians in making monetary contributions to or otherwise supporting an AMA-established super PAC.

RECOMMENDATION

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 AMA policy state that the use of AMA corporate funds, including reserves, is not a fiscally responsible option for funding a super PAC, especially given the 35 percent excise tax imposed on the use of such funds, and because of the lack of a reliable and sustainable outside funding source and the absence of interest among AMA member and non-member physicians, creation of a super PAC should not be pursued.

17. PHYSICIAN ENTREPRENEUR ACADEMY

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-630.969

Policy D-630.969, "Physician Entrepreneur Academy," adopted at the 2015 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) states:

> Our American Medical Association will study the possibility of developing an entrepreneur and business training academy to offer online and onsite training and skill development for AMA members.

DISCUSSION

A growing number of physicians are involved in the development and business side of medicine outside their traditional roles of directly delivering patient care. Many physicians, especially young physicians, are attracted to the innovations that through technology or by other means improve medical practice. Surveys, interviews, and engagement opportunities for students and physicians demonstrate a high level of interest in entrepreneurship. Feedback from our governing bodies, especially members of the Medical Student Section, Resident and Fellow Section, and Young Physicians Section have confirmed the interest that has been demonstrated by physicians at-large. A Physician Entrepreneurship Academy can provide skill training for physicians who would like to contribute to the practice of medicine through entrepreneurial and business activities. Further, an academy can also help physicians understand the value of their contributions to entrepreneurial and business activities, so they may seek fair compensation, when appropriate. Increasing physician business insight can create a more level playing field where physicians are not taken advantage of by more savvy business-minded professionals.

In response, over the last two years, our AMA began a number of initiatives specifically aimed at enhancing physicians' business and entrepreneurial acumen, including the creation of a physician-entrepreneur speaker series, the development of an online platform to connect physicians with entrepreneurs, and opportunities for mentoring relationships.

In 2015, our AMA began the Physician Entrepreneur Speaker Series with events in Chicago, San Francisco, and Atlanta that featured panels of successful physician entrepreneurs. This year a "Speakers Series" event was held in New York and more will follow during 2016 in Austin, Texas and Chicago. Combined attendance at the first four events exceeded 300 AMA members, including those physicians who joined the AMA in order to attend at a reduced rate.

Our AMA also developed a small-scale pilot for a physician-entrepreneur matching website, with the intent of creating two-way mentoring opportunities. Entry into the website requires both physicians and entrepreneurs to register and to identify specific areas of interest. A list of potential matches is then provided. Entrepreneurs are able to directly connect with one another and communicate privately through the website. Physicians are able to find and learn from entrepreneurs with common interests. Physicians are able to educate entrepreneurs on the day-to-day processes required to deliver quality patient care. The initial pilot included members of our AMA's Young Physicians Section. To date, over 200 AMA members have signed up to participate in the pilot. We are currently assessing the interest to participate by other entrepreneurial organizations.

Our AMA is a Founding Platinum Sponsor of MATTER, which welcomes entrepreneurs and industry leaders from a range of fields—including healthcare IT, medical devices, diagnostics and biopharma—who are committed to creating products and services that advance the health care industry. This community consists of over 120 health care startups, and more than 65 partner organizations. Our AMA has sponsored the AMA Physician Interaction Studio, 450+ square feet within MATTER's space, to facilitate two-way dialogue between entrepreneurs and physicians. MATTER has developed an entrepreneurship education curriculum consisting of 50-75 courses, across 11 different domains. Because of our sponsorship, AMA members can attend these classes in person at no cost. We are currently discussing with MATTER the possibility of recording these sessions and making them available to our members at no charge.

CONCLUSION

Our AMA's creation of a physician-entrepreneur speaker series, the development of an online platform to connect physicians with entrepreneurs, and sponsorship of MATTER is a demonstration of our commitment to making entrepreneurial education and opportunities available to our members. Making MATTER's curriculum available to AMA members at no cost, whether in person or online, will enable interested physicians to build their desired entrepreneurship and business skills. Your Board of Trustees anticipates expansion of the offerings in the future.

RECOMMENDATION

The Board of Trustees recommends that AMA Policy D-630.969, "Physician Entrepreneur Academy," be rescinded and that the remainder of the report be filed.

18. INCREASING COLLABORATION BETWEEN PHYSICIANS AND THE PUBLIC TO ADDRESS PROBLEMS IN HEALTH CARE DELIVERY

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-160.904

Policy H-160.904, "Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery," adopted at the 2015 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) states:

1. Our American Medical Association will consider methods to further engage the public in support of AMA measures designed to improve the delivery of quality medical care.

2. Our AMA will consider the creation of a Citizens Advisory Group, consisting of patients, lay caregivers, and other non-physician members, to assist the Board of Trustees and the House of Delegates, with goals including but not limited to: (a) attaining full understanding of the problems confounding the delivery of quality medical care; (b) providing the Board of Trustees and House of Delegates with commentary regarding these pertinent issues; (c) articulating these concerns and issues to the public at large; and (d) encouraging the public to communicate their concerns and recommendations to their elected officials in a timely fashion.

This report summarizes our AMA's considerable efforts to engage the public and therefore, recommends against the creation of a Citizens Advisory Group.

DISCUSSION

Over the past two years, our AMA has made significant strides in its engagement with physicians and the public through digital opportunities on its social media channels and the blog AMA Wire. These robust communications platforms reach a diverse and sizable audience and consistently create opportunities for ongoing dialogue about the essential goals of our AMA.

AMA Wire is an example of a far-reaching broad-topic engagement opportunity that establishes a relationship with the viewing audience. Posting more than 500 stories each year about topics ranging from practice sustainability to physician wellness to hypertension and prediabetes, AMA Wire drew more than 1.5 million page views in 2015. Annually, AMA Wire also receives more than 1,500 reader comments, which are monitored by community managers looking for strategic opportunities to share with AMA leadership. Due to the breadth of the subject matter posted on AMA Wire, this provides an outstanding venue for dialogue with readers on problems confronting the delivery of quality medical care.

Our AMA has also found great success in reaching and engaging a broader audience through campaign-specific efforts. The Break the Red Tape campaign maintains "BreakTheRedTape.org" as its online hub and provides site visitors the ability to learn more about Electronic Health Records (EHRs) and Meaningful Use (MU) requirements that physicians are forced to comply with. Physicians and patients alike have the ability to share their own stories on these topics and how they feel the system could be improved. To date, the site has published 103 written statements and recorded videos. Those interested in speaking out on the issue with their member of Congress can also use tools on the site to send messages calling for repeal to lawmakers through email and social media outlets. In addition, BreaktheRedTape.org has served to promote and broadcast via live stream, town hall events in Atlanta, Boston, and Seattle that physicians attended to discuss EHRs, MU, and the future of regulations impacting EHRs. These interactive events were hosted by our AMA in conjunction with state medical societies and featured AMA President Steven J. Stack, MD, the state medical society leadership, and other experts in the field. In all, over 900 individuals took part in these events either in-person or through watching at BreakTheRedTape.org.

A third example of our AMA's ability to initiate meaningful dialogue involves the launch of a social campaign called #AHealthierNation. Launched in September of 2015, this campaign has encompassed two tweet chats and one Google Hangout with topics ranging from the role physicians should play in the evolution of health technology to how the new SPRINT trial and other recent studies impact the management of high blood pressure. By convening an audience of influential healthcare voices and members of the public on social media, this endeavor served to reinforce our AMA as a thought leader and facilitator of dynamic conversation.

These three examples do not constitute the entirety of our AMA's work to engage and learn from a broader audience, but they do represent excellent examples of nimble, sustainable, and strategic digital approaches that can scale to reach large audiences and maximize our potential impact. Conversely, the creation of a Citizens Advisory Group, poses challenges that must be considered.

LOGISTICAL CHALLENGES

Several factors that contribute to the formal creation of a Citizens Advisory Group highlight how cumbersome the potential process could be. Among the factors:

- How are the individuals selected and who do they represent?
- What is the appropriate group size to represent the desired diversity of background?
- Can this group be convened for in-person meetings in a cost-effective manner?
- How frequently must the group be assembled to make it mutually beneficial?
- What is the duration for someone to remain a member of the group?

CONCLUSION

The cost-prohibitive nature and logistical challenges of assembling ongoing face-to-face conversation with the public has led the Board of Trustees to consider digital engagement options that can expand the voices represented to provide commentary regarding the problems confronting the delivery of quality medical care. Due to the ongoing success of the engagement efforts cited in the discussion above, the Board of Trustees believes that the creation of a Citizens Advisory Group is not an effective use of AMA resources for achieving the desired diversity of opinions and ideas. We anticipate that engagement with our audience will continue to deepen as our digital ecosystem launches new features and opportunities to articulate concerns to the public at large in the coming months. Following the launch of a new corporate website and AMA Wire in 2016, further consideration will be given toward establishing a sustainable mechanism that returns audience feedback to AMA leadership on a regular basis.

RECOMMENDATION

The Board of Trustees recommends that AMA Policy H-160.904, "Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery," be amended by substitution to read as follows and that the remainder of the report be filed:

> Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care.

19. PAIN AS THE FIFTH VITAL SIGN
(RESOLUTION 707-A-15)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-185.931, D-120.971, D-160.981 and D-450.956

INTRODUCTION

At the 2015 Annual Meeting, the House of Delegates (HOD) referred Resolution 707-A-15, "Pain as the Fifth Vital Sign," introduced by the New York Delegation, which asked:

> That the American Medical Association adopt as policy the position that the clinical highlighting of pain as "fifth vital sign" and a focus on eradication or total resolution of a patients pain is misguided and leads to 1) inappropriate pain management demands by patient; 2) inappropriate pressure on clinical pain management practices by clinicians; and 3) consequently, the diffuse overuse of opioids;
>
> That the AMA recommend that "pain as the fifth vital sign" be removed from the clinical practice environment; and
>
> That our AMA encourage The Joint Commission remove "pain as the fifth vital sign" from its standards.

During Reference Committee, testimony was mixed and highlighted the fact that the history of "pain as the fifth vital sign" was complicated, although there was clear support for the need to ensure patients had access to comprehensive pain care services as well as to reduce the stigma of pain.

This report clarifies the history of how "pain as the fifth vital sign" evolved as a framework; provides an update on how various stakeholders perceive the issue; addresses the work of our AMA and our AMA Task Force to Reduce Opioid Abuse in working to support pain care and reducing stigma; and makes recommendations regarding appropriate AMA policy considerations.

BACKGROUND

Pain is one of the most common reasons for patients to seek medical attention and one of the most prevalent medical complaints in the United States. The Institute of Medicine estimates that chronic pain affects more than 100 million Americans.

During the past two decades, growing numbers of patients with persistent non-cancer pain have been offered long-term opioid therapy. This change in prescribing behavior was preceded by development of the World Health Organization analgesic ladder and new guidelines and support from the federal government addressing the under-treatment of acute post-surgical and cancer pain that endorsed more aggressive use of opioid analgesics. During the same time period, attention also shifted to patients with chronic non-cancer pain. Conclusions about the safety and efficacy of opioids in acute and cancer pain were extended to patients with chronic non-cancer pain, even in the absence of evidence obtained from long-term, randomized controlled trials. Several short-term randomized controlled trials, clinical surveys, uncontrolled retrospective surveys, and case series on opioid use in patients with chronic non-cancer pain said therapy is beneficial in the treatment of selected patients with chronic pain and such therapy may be underutilized. Combined with the availability of a new array of more potent products and promotional activities by the pharmaceutical industry, limited formal education about pain management and substance use disorders, new Joint Commission pain standards and the advent of patient satisfaction surveys, the rate of opioid prescribing increased dramatically. With this increase came an unprecedented increase in various measures of harm attributable to opioid analgesics including increased emergency department visits, addiction, and unintentional overdoses and death.

In both hospital and outpatient settings, the notion of "pain as the fifth vital sign," and the evolution of patient satisfaction surveys that include a focus on the extent to which a patient's pain is relieved, created a practice environment that, although intended to promote pain assessment and effective treatment, in general likely contributed to an increase in opioid prescriptions. Despite the substantial burden of persistent pain in the United States, access to multidisciplinary care and insurance coverage for non-pharmacologic approaches is woefully inadequate. All of these factors may have contributed to the routine use of opioid analgesics.

DISCUSSION

The first notion of "pain as the fifth vital sign," is often attributed[1] to a speech in 1996 by James Campbell, MD, of the American Pain Society (APS), who emphasized the need to include pain as a vital sign along with body temperature, blood pressure, heart rate, and respiratory rate.

In 2000, the US Veterans Health Administration (VHA) issued a revised version of its "Pain as the Fifth Vital Sign Toolkit" (the Toolkit), to provide resources for physicians and other health care professionals.[2] The Preface to the Toolkit attributed the phrase, "pain as fifth vital sign" to the APS. The VHA emphasized that "pain as the fifth vital sign" is a screening mechanism for identifying unrelieved pain. Screening for pain can be administered quickly for most patients on a routine basis. As with any other vital sign, a positive pain score should trigger further assessment of the pain, prompt intervention, and follow-up evaluation of the pain and the effectiveness of treatment."

The following year, The Joint Commission revised its accreditation standards to require organizations to assess and manage their patients' pain appropriately, to enhance their understanding of pain management techniques, and to ensure accountability for the management of pain within the organization.[3] The Joint Commission did not, however, adopt pain as a vital sign in any official standard, according to testimony provided by The Joint Commission before our HOD. Therefore, while it is clear that The Joint Commission is often perceived[4] as having adopted "pain as the fifth vital sign", the recommendation in Resolution 707-A-15 that asks our AMA to "encourage The Joint Commission to remove pain as the fifth vital sign from its standards" is considered a moot point.

Although prescriptions for opioid analgesics have demonstrated a continuing upward trend over the last two decades, there has been a growing sense that patients' pain has not been adequately treated. In 1997, the Federation

of State Medical Boards (FSMB) adopted its first model policy on the use of controlled substances to treat pain. The FSMB issued a revision in 2004, which strongly discouraged the under-treatment of pain. In 2013, the FSMB published a "Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain" (Model Policy).[5] The 2013 Model Policy presented a much more complex discussion on both the benefits and harms associated with the use of opioids to treat chronic, non-cancer pain. It also recognized that inadequate relief of pain remained an issue for many Americans.

Many state and national medical specialty societies have developed guidelines and other recommendations for the treatment of acute and/or chronic pain.[6] These guidelines and recommendations, generally, have focused on the appropriate treatment of pain. In 2014, our AMA convened the AMA Task Force to Reduce Opioid Abuse (the Task Force) with the American Osteopathic Association, American Dental Association, and more than 20 leading state and national medical specialty societies. The Task Force was formed, in part, because overdose deaths linked to prescription opioids have been increasing rapidly, and the AMA Board of Trustees wanted to take advantage of the broad expertise within organized medicine to identify and implement physician-oriented solutions to end the epidemic.

Among the Task Force recommendations for ending the nation's opioid epidemic is the recommendation to "reduce the stigma of pain and promote comprehensive assessment and treatment." Specifically, the Task Force–through AMA communications channels, presentations by staff and leadership, and through Task Force organizations–has supported efforts to reshape the current national dialogue on opioid analgesics. The current environment leaves many patients with pain who might benefit from opioids afraid of becoming "an addict" and many physicians afraid to prescribe opioids, even when their use reduces pain and improves function.

At the other end of the spectrum, but equally problematic, is that the current social and medical context in this country leads to patient expectations of complete pain relief; the media refers to opioid analgesics as "painkillers" and for many reasons, opioids have been relied on as the preferred and sole treatment for pain. The Task Force has sought to place increased emphasis through educational outreach–for patients and physicians and the general public–on appropriate care for patients with chronic pain, which is best achieved through a multimodal approach. This may or may not include opioids. The Task Force also has emphasized prevention and early intervention for the treatment of acute pain so that it does not become chronic pain.

The Task Force efforts, moreover, are in line with multiple AMA policies that support a comprehensive, balanced approach for treating patients' pain, rather than a focus on eradication or total resolution of a patient's pain. These policies include D-160.981, "Promotion of Better Pain Care," which provides, in part, that the AMA "will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine;" D-120.971, "Promoting Pain Relief and Preventing Abuse of Controlled Substances," calls on the AMA to, among other things, "(1) urge the Drug Enforcement Administration (DEA) to publicly restate their commitment to balance in promoting pain relief and preventing abuse of pain medications; and (2) support an ongoing constructive dialogue among the DEA and physician groups to assist in establishing a clinical practice environment that is conducive to pain management and the relief of suffering, while minimizing risks to public health and safety from drug abuse or diversion;" and H-185.931, "Coverage for Chronic Pain Management," which states that:

1. Our American Medical Association will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.

2. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.

3. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.

Thus, AMA policy as well as AMA advocacy and the work of our AMA Task Force to Reduce Opioid Abuse emphasize the need for comprehensive pain care–and reducing the stigma of pain.[7]

With respect to "inappropriate patient demands," this also is an area where many medical societies, including those on the Task Force have worked to emphasize appropriate pain care. In some instances, this requires the physician to recommend non-opioid or non-pharmacologic alternatives.

Our AMA recently adopted policy addressing patient satisfaction surveys with this view in mind. However, it should also be noted that access to non-opioid and non-pharmacologic treatment for pain is often beyond the ability of the physician to provide due to lack of ready access to alternative therapies in a patient's community, prior authorization restrictions or step therapy or "fail first" protocols by health plans, or inadequate insurance coverage for multidisciplinary care. In fact, a recent AMA national survey found that 43 percent of respondents indicated that lack of coverage of an alternative to opioids was a major barrier to non-pharmacologic and non-opioid therapies.[8] In other words, sometimes the physician's hands are tied, and the pressure to provide an opioid or other treatment intensifies. Obtaining health plans' support for physicians' efforts to provide comprehensive approaches to treat pain is an important component to ending the nation's opioid epidemic.

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 707-A-15, and that the remainder of the report be filed.

1. That our AMA work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards;

2. That our AMA reaffirm D-160.981, "Promotion of Better Pain Care," H-185.931, "Coverage for Chronic Pain Management," and D-120.971, "Promoting Pain Relief and Preventing Abuse of Controlled Substances."

3. That our AMA strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care.

4. That our AMA advocate that pain as the fifth vital sign be eliminated from professional standards and usage.

5. That our AMA advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.

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6 *See*, for example, Washington State Department of Health Pain Management, available at http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PainManagement; Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments, available at http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf
7 See AMA Chair-elect Patrice A. Harris, MD, comments to the National Governors Association, Feb. 20, 2016. Available at http://www.ama-assn.org/resources/doc/washington/harris-statement-nga-feb2016.pdf
8 Physician perceptions and practices on opioid prescribing, education, barriers to care, naloxone. TNS, Kantar Group. Survey conducted Nov. 13-15, 2015.

20. PRINCIPLES FOR MEASURING AND REWARDING PHYSICIAN PERFORMANCE (RES. 716-A-15)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-450.947, H-450.966, H-450.994 and H-450.999,

At its 2015 Annual Meeting, the House of Delegates (HOD) referred Resolution 716-A-15, "Principles for Measuring and Rewarding Physician Performance," to the Board of Trustees. Resolution 716 was introduced by the Organized Medical Staff Section and asked that our American Medical Association (AMA):

> study and consider adopting as AMA policy the proposed "Principles for Measuring and Rewarding Physician Performance." (The proposed policy is reproduced in full in Appendix A.)

DISCUSSION

Health care quality management uses data to evaluate the performance of physicians and other health care providers against recognized quality standards. While the concept of quality management has evolved over the past two decades, its aim is steadfast to improve clinical outcomes and patient experiences, as well as to increase accountability and transparency. Today, physicians are judged by systematic measurement and reporting of their performance on selected quality indicators, by patient experiences with the care received, and by assessment of the appropriateness and cost-effectiveness of care.

Resolution 716 suggests that the AMA has a responsibility to take a leadership role in quality measurement and improvement and, accordingly, proposes a number of wide-ranging principles for physician performance measurement in an effort to ensure that accurate, comprehensive, and relevant clinical data is being collected to assess the quality of clinical practice. The proposed principles span all stages of performance measurement programs, from inception and development to the use and distribution of performance reports.

Although it is not disputed that the AMA has a responsibility to take action in this area, a comparison of the proposed principles to existing AMA policy reveals that the two are substantially similar. A comprehensive list of related/overlapping AMA policies is included in Appendix B. Given the length, detail, and nuance of both the proposed principles and related AMA policy, a comprehensive crosswalk of the two sets of policies is not practical. However, to illustrate the fundamental parallels between the proposed principles and existing AMA policy, we present below a comparison between the overarching principles outlined in the preamble to Resolution 716 and current AMA policy.

Use of objective, well-validated, and clinically important measures of quality

AMA Policy H-450.966 states that all quality measures must be prospectively defined and representative of the range of health care services commonly provided by those being measured. This policy also requires the use of evidence-based quality of care measures as the primary measures used in any program.

Ensure accurate and timely assessment of these measures

AMA Policy H-450.947 addresses the need for quality improvement programs to use accurate administrative data as well as data abstracted from medical records, and also requires results to be based on data collected over a significant period of time, and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

Include physicians in both primary care and medical specialties

AMA Policy H-450.966 wholly supports collaboration across physician specialties throughout the development of all performance measures used in quality improvement programs, and highlights the importance of all organizations developing performance measures to include actively practicing physicians and physician organizations. AMA

Policy H-450.966 also urges national medical specialty societies and state medical associations to participate in developing, implementing, and evaluating performance standards and measures.

Provide for timely review of reports by involved physicians prior to public release

AMA Policy H-450.947 supports allowing physicians the opportunity and ability to review and/or comment on data and analysis that is used to construct any performance rating–prior to using such rating to determine physician payment or for public reporting.

Ensure that reports released to the public can be easily and accurately interpreted

AMA Policies H-450.994 and H-450.999 support the development of educational programs that inform the public about the various aspects of quality assurance, and specifically urge state and local medical societies to consider developing public information programs to inform consumers about existing quality assurance activities. AMA Policy H-450.994 further recommends that health care facilities, as well as national and local health care organizations, make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality.

Make appropriate use of risk-adjustment and statistical methods when reports aim to compare performance among clinical practices or hospitals or make clear notation that population differences make direct comparisons difficult or impossible

AMA Policy H-450.947 not only requires performance measures to be subject to the best available risk-adjustment for patient demographics, severity of illness, and co-morbidities, but also recommends that quality improvement programs allow for further variance from specific performance measures that are in direct conflict with sound clinical judgment.

Use appropriate incentives to reward superior performance and stimulate continuous improvement in the quality of care being provided

AMA Policy H-450.947 encourages quality improvement programs to reward all actively participating physicians who achieve pre-specified absolute program goals, or have demonstrated pre-specified relative improvement toward program goals.

Promote and facilitate the adoption of information technology (IT) tools including electronic health records (EHRs)

The AMA supports the advancement of health IT and the use of EMRs as crucial to improving quality of care and patient safety. AMA Policy H-450.947 states that quality improvement programs should provide physicians with tools (i.e., IT systems and software) to facilitate participation. To further protect physician interests, AMA Policy H-450.947 also specifies that programs must avoid implementation plans that require physician practices to purchase health plan-specific IT capabilities.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 716-A-15, and the remainder of the report be filed:

That the following key American Medical Association policies relating to quality improvement be reaffirmed:

- H-450.947, “Pay-for-Performance Principles and Guidelines;”
- H-450.966, “Quality Management;”
- H-450.994, “Quality Assurance in Health Care;” and
- H-450.999, “Practice Evaluation.”

Appendix A - Proposed Principles for Measuring and Rewarding Physician Performance (from Resolution 716-A-15)

Increasingly, physicians are being judged by systematic measurement and reporting of their performance on selected quality indicators, by patient experiences with the care received, and by assessment of the appropriateness and cost-effectiveness of care. Quality improvement programs that have these goals should:

- use objective, well-validated, and clinically important measures of quality;
- ensure accurate and timely assessment of these measures;
- include physicians in both primary care and medical specialties;
- provide for timely review of reports by involved physicians prior to public release;
- ensure that reports released to the public can be easily and accurately interpreted;
- make appropriate use of risk-adjustment and statistical methods when reports aim to compare performance among clinical practices or hospitals or make clear notation that population differences make direct comparisons difficult or impossible;
- use appropriate incentives to reward superior performance and stimulate continuous improvement in the quality of care being provided;
- promote and facilitate the adoption of information technology (IT) tools including electronic health records (EHRs).

A. Goals of Performance Measurement

- The primary goal of performance measurement is to improve the quality of health care by providing physicians with meaningful information on their clinical performances. Hence, success should be measured by evidence of improvement over time in the structures, processes, and outcomes of care.
- Other important goals are to ensure physician accountability to the needs of health care consumers and accrediting and regulatory entities.
- Physician leadership is essential in developing and implementing performance measurement activities to ensure their clinical relevance and to help inform patients and the community about aspects of health care that are particularly important to physicians.
- Performance measurement must address local, as well as regional and national, priorities if local needs are to be satisfied and active physician participation is to be assured.

B. General Principles of Physician Performance Measurement

- Performance measures should be clinically relevant to the individual physician or group practice being evaluated. Markers of importance include high prevalence; significant impacts on mortality, morbidity, or costs; and high degrees of practice variation where variations have well-documented relationships to health outcomes.
- Physicians should be evaluated only with respect to patients and clinical services for whom/which they are directly responsible. Where responsibility for care is shared, the team, group practice, or hospital service should be the unit of evaluation. When attribution is uncertain, evaluation should be at the higher level of aggregation.
- Performance measures should, to the maximum extent possible, be firmly grounded in scientific evidence. Where the science base is inadequate, professional consensus may be substituted. In either case, sources of support for the measure and their validity should be fully documented and readily accessible.
- The process for selecting the range of performance measures to be included should take into account the perspectives of all involved parties including physicians, patients, health plans, provider organizations, employers, payers, and regulatory agencies.
- Quality measures must be clinically important, prospectively defined, and designed for objective and accurate measurement. They should be evidence based and directed at medical specialists as well as primary care physicians. Measures aimed at health care outcomes are preferred. Measures should adjust for case mix, distinguish between ordering and referring physicians, and other factors such as race and ethnicity if empirical evidence suggests a correlation (AMA, NQF). Measures aimed at processes of care are also important if they are closely linked to improved outcomes.
- Many quality measures used today, including Health Plan Employer Data and Information Set measures, are of marginal clinical importance. Such data should not be used in the physician peer-review process. Physician peer review should be conducted in accordance with the AMA's Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA policy H-375.965).
- Technical barriers to accurate and timely measurement of quality need to be confronted. As sources of data, claims data have the advantages of being readily available, relatively low in cost, and inclusive of important parameters such as diagnostic and procedure codes. Shortcomings include delays in obtaining access to the data, inaccuracies, and inadequate information on the clinical needs of patients and socioeconomic indicators that may affect outcomes. Standardization of EHRs is central to improved measurement, as interoperability will allow for coordinated and complete data collection. The development of such systems should be a high priority.
- The costs of quality measurement can be considerable. Costs should be justified by tangible evidence of resulting improvements in health care quality and/or savings in the costs of health care. Measures of cost should include the added clerical burdens on physician practices or managed care organizations.
- Physicians should be intimately involved in all aspects of quality measurement in: developing quality measures, implementing and monitoring quality measurement, and reporting results to practices and the public. To these ends, physicians should work in close collaboration with payers, quality measurement organizations, and regulators.

C. Development of a Performance Measurement Program

- Development of effective performance measurement programs requires close collaboration among physicians, their health care organizations, payers, and regulatory agencies.

- Expected benefits of performance measurement should be weighed against the burden and costs for the program as a whole, and for each performance measure. The value of performance measurement will be increased by the use of standardized measures and methods, avoidance of duplication of effort, and steps to ensure the accuracy and usefulness of results.
- Ongoing performance measurement activities should receive regular external evaluations. These evaluations should focus on the choice of performance measures, data collection and analysis strategies, the accuracy of the results obtained, and the appropriateness of interpretation of results.
- Organizations that conduct performance measurement (provider organizations and vendors) should disclose fully their performance measurement objectives, policies, and methods, and make these readily accessible to both the physicians being assessed and the public.
- The burden and costs of performance measurement should be fairly allocated among those who will potentially benefit including physicians, patients, health plans, payers, employers, and regulatory agencies.

1. Characteristics of Performance Measures
- Measures should be based on data available to the clinician in the real-time clinical setting and should have clear implications for actions to improve the quality of care.
- Measures should be standardized and capable of systematic and objective measurement. Relevant data sources must be available, accurate, and reasonably complete.
- To the extent possible, measures should rely on data that are routinely collected during usual patient care.
- The burden of data collection for a measure should be reasonable.
- Measures should be updated at regular intervals to reflect changes in medical knowledge or the norms of practice.
- Measures of clinical outcomes should be risk-adjusted so that results appropriately reflect patients' severity of illness at the time of presentation or time of clinical action. Methods used for risk-adjustment should be accurate at all levels of severity of the illness.
- Measures and associated analytic methods should be clearly defined and fully disclosed to necessary parties. Measures based on un-disclosed algorithms or software are not acceptable.

2. Types of Performance Measures
- Clinical outcome measures should be clearly related to processes of care that are under the control of the physician or group practice, and can be modified to affect the outcome.
- Process measures should be clearly linked by scientific evidence to direct effects on patient outcomes. They usually relate to diagnostic and treatment decisions but may also examine access to care or compliance with care regimens.
- Patient perceptions of and satisfaction with the quality of services are important. Patients should have input into the selection of these measures.
- Patients are often the best witnesses to assess the outcomes that they experience.
- Resource use and cost measures should be supported by evidence that patient care will not be adversely affected and expectations for benchmarks should be appropriate. When efficiency measures are used, quality measures should be used in conjunction with such measures to ensure there is appropriate utilization. Decisions on the use of such measures should include individuals with no direct financial stake in the care being evaluated.
- The primary purpose of performance measurement related to resource use and costs should be to raise awareness and inform quality improvement activities. Results should not be used for punitive purposes except in cases of flagrant overuse or clear waste.

3. Data Sources
- Each data source should meet explicit standards of accuracy and completeness if valid comparisons are to be made among physicians or practices.
- The data source should be appropriate to the performance measure being examined.
- The data source should be readily available in all practices or health plans being compared.

4. Data Collection
- Data collection protocols should be explicit, as objective as possible, and limited to essential items of data.
- Data collection from medical records or by survey should be performed by persons skilled in the methodology. Ideally, these individuals should be selected and reimbursed in a manner that will optimize objectivity and minimize bias.

5. Data Analysis
- The level of analysis (individual physician, group practice, or health plan) should be appropriate to the ability of data to support meaningful analyses and the intended use of the report. Sample sizes of events or cases that are too small to support analyses at the level of the individual physician may be useful for internal quality improvement but should not be released to the public.
- Analyses should be planned and conducted by individuals who are skilled in appropriate analytic techniques.
- Analytic techniques should be appropriate to the objectives of the analysis and the database.
- Reports should emphasize important differences between the entities being compared or time trends in performance, and include clear statements about the statistical significance and clinical importance of results.
- Reports that are to be released to the public should be based on adequate sample sizes and accurate data, and meet high standards of statistical validity. Independent external audits should be performed prior to release.

- Reports that are for internal discussion/use in quality improvement activities can be based on smaller sample sizes and may not require formal statistical analysis.
- Methods of analyses should be described in sufficient detail that results can be easily understood and, if necessary, reproduced.

6. Risk-Adjustment

- Adequate risk-adjustment is essential to achieving valid comparisons among physicians, practices, or health plans on clinical outcomes and the appropriateness of decisions to perform surgical or diagnostic procedures.
- Simple adjustment for selected patient characteristics such as age, gender, and risk factors for the disease will be sufficient for certain process measures (e.g., mammographic screening for breast cancer).
- Risk-adjustment models should be carefully tested before they are used and should have demonstrated good calibration between predicted and actual outcomes at all levels of severity of illness. Generic risk-adjustment models can be used if they have been demonstrated to be valid for the particular condition and the particular type of clinical setting.
- The risk-adjustment methodology should be well-documented and open to inspection, preferably published in the peer-reviewed medical literature.

D. Distribution and Use of Performance Reports

- Physicians and physician groups being assessed should be the first to receive all reports that measure their performance. They should be given an opportunity to review and comment on reports prior to external release. In particular, physician "outliers" on a measure should be contacted to detect any unusual circumstances that explain the result. Documented errors should be corrected, and substantive comments or explanations should be appended.
- External distribution of physician performance results should be governed by the necessary parties as defined by the responsibilities of the entity and the content of the report. Criteria for external distribution, including rules governing confidentiality of content, should be explicitly stated and agreed to by all involved parties. For example, the public should receive reports that will help them select a physician, health plan, or hospital. Regulatory agencies should only receive information specified in their credentialing standards.
- Organizations that use physician performance reports should publicly disclose the types of information they need and how this information will be used to improve the quality of health care.
- Reports intended for public release should meet higher standards of accuracy, reliability, and statistical validity than those intended for internal discussion/use only. Reports should not be released when there are too few cases to support a meaningful analysis. Appropriate risk adjustment of results is essential. Reports intended for public release should be audited by an independent entity prior to their release.
- All reports, whether for internal or external use, should be clear and unambiguous and accompanied by materials that facilitate proper interpretation. Reports should be protected from discovery during legal proceedings.
- Performance reports used for internal quality improvement should remain confidential between the physician or physician group being measured and their immediate supervisors. Such reports should be protected from disclosure by peer review regulations, whenever possible.
- Reports keyed to sentinel events should be used only for internal quality improvement unless statistically valid patterns of performance can be documented.
- Patient-specific data may, where necessary, be released to the patient's physician for use in internal quality improvement activities. Broader release of patient-specific data, however, should require explicit permission of the patient.

E. Public Reporting of Physician Performance

- The public expects and deserves valid reports on the performance of all health care providers: medical practices, managed care organizations, hospitals, nursing homes, and other services.
- Reports for public release must meet high standards for accuracy and statistical validity. Reports should not be released when there are too few cases to support a meaningful analysis. They should receive timely review by involved practices prior to release, and should be corrected for discovered errors or risks of misinterpretation. Particular attention should be given to ensure that physicians are held accountable only for care for which they are, in fact, responsible.
- Reports that compare performance of physicians or practices to each other or to benchmarks must avoid using arbitrary cutpoints that designate practices as being "superior," "above average," "average," or the like. Instead, performance should be rank-ordered according to the quality measure under consideration. Ranking should be based on clinically important and statistically significant differences.
- Reports must pay careful attention to differences in sociodemographic and socioeconomic classes and cultural divides that may affect patient attitudes toward health care and adherence to recommendations of their physicians.

F. Frequency of Performance Reports

- The frequency of reports depends on the intended purpose. If the goal is to achieve behavior change and quality improvement, frequent reinforcement by quarterly reports may be required. Annual reports are usually sufficient for comparisons among health plans or to satisfy accrediting agencies.
- The burden of data collection and other costs of performance measurement will be limiting factors both for the selection of performance measures and the frequency of reports.

G. Assessing the Quality of Patient-Physician Relationships

- Quality-measurement programs should be directed at supporting and improving patient-physician relationships. To these ends, they must reflect the vital importance of sound medical judgments as well as adherence to defined guidelines.
- Programs should protect and improve access to high-quality health care for all patients. Program developers should be especially sensitive to minimizing barriers to access among patients who are disadvantaged by reason of ethnic, cultural, and socioeconomic barriers, or who have especially complex medical conditions, and should take positive steps to improve access to care for such patients.
- Programs should aim to achieve equity in quality assessment for patients and their physicians, regardless of the setting in which care is delivered or the location of the population served (for example, inner city or rural areas). This challenge will be particularly difficult in practice settings that lack the needed infrastructure, including EHRs.
- Programs should be "risk-adjusted" to reflect the important effects of patient non-adherence on performance outcomes. This is especially important when patient adherence is not reasonably under the control of the physician.

Paying for Performance (P4P)

- Criteria, methodology, and background data for P4P on measures of quality and cost should be transparent to all involved. Practices involved with these incentives should have an opportunity to review their data and, preferably, begin improvement prior to the implementation of the incentives.
- Monitor evidence on pay for performance and its effect on improving quality indicators in diverse practice settings.
- Funding of P4P initiatives should come from additional resources. Financial incentives should not come from a redistribution of current physician and other health care provider reimbursement.
- Requirements to achieve P4P goals should be made known to physicians in a timeframe that will allow them to safely alter the care they deliver in order to meet the goals. Incentives should seek to move practices to the "next level" in terms of acquiring essential structural components (for example tracking systems or EHRs) that will improve processes or outcomes of care.
- P4P pilots should use incentives of sufficient magnitude to influence physician behaviors. Results should be carefully monitored to ensure that the intended objectives are met and that unexpected detrimental effects have not been introduced.
- P4P incentives should be aligned and standardized across payers, physician practices, and hospitals.
- Pay-for-performance statistics shall be applied only to those patients to whom the peer-reviewed medical evidence is applicable, including such criteria as: demographic characteristics, clinical characteristics, clinical significance, and life expectancy.

Appendix B - Related AMA Policy

H-450.947 Pay-for-Performance Principles and Guidelines
1. The following Principles for Pay-for-Performance and Guidelines for Pay-for-Performance are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS
Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles: 1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards. 2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns. 3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up. 4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting. 5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS
Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care
- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program. 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties. 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program. 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. 4. Performance measures should be scored against both absolute values and relative improvement in those values. 5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities. 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years. 7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship
- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care. 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation
- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).1. Programs should provide physicians with tools to facilitate participation.2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting
- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.1. Programs should use accurate administrative data and data abstracted from medical records. 2. Medical record data should be collected in a manner that is not burdensome and disruptive to

physician practices.3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards
- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14)

H-450.966 Quality Management
The AMA: (1) continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. (BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed in lieu of Res. 714, A-14; Reaffirmed in lieu of Res. 814, I-14; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15)

H-450.994 Quality Assurance in Health Care
(1) Accountability through voluntary, professionally directed quality assurance mechanisms should be part of every system of health care delivery. The cost of quality assurance programs and activities should be considered a legitimate element in the cost of care. (Reaffirmed: Res. 711, A-94) (2) To fulfill their fundamental responsibility to maximize the quality of services, health care institutions should establish, through their governing bodies, a formal structure and process to evaluate and enhance the quality of their health care services. This should be accomplished by participation of the professional staff, management, patients and the general public. When appropriate, health care institutions should be urged by licensing and accrediting bodies to establish a formal committee to coordinate all quality assurance activities that occur among the various health care professions within the facility. (3) Voluntary accreditation programs with standards that exceed those of state licensure and that focus on quality of care issues should be offered to all health care facilities. Various agencies that accredit health care facilities should develop a formal interagency structure to coordinate their activities and to resolve any inter-organizational problems that may arise. (4) Public and private payment programs should limit their coverage for services provided in health care facilities to those that meet professionally acceptable standards of acceptable quality, should structure their reimbursement to support the improvement of quality, and should provide information on quality for the benefit of their subscribers. (5) Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and in continuing education programs. (6) Educational programs should be developed to inform the public about the various aspects of quality assurance. Health care facilities and national and local health care organizations should make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality. (7) Research should be undertaken to assess the effects of peer review programs and payment mechanisms on the overall quality of health care. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-450.995 Quality of Care - Essentials and Guidelines for Quality Assessment
(1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient; (b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions; (c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care; (d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process; (e) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources; (f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare; (g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and (h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation. (2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed. (b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable. (c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible. (d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment. (e) Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach. (f) Both explicit and implicit criteria are useful in assessing the quality of care. (g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment. (h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance. (i) The quality assessment process itself should be subject to continued evaluation and modification as needed. (CMS Rep. A, A-86; Reaffirmed: CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)

H-450.946 Ensuring Quality in Health System Reform
Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed-upon principles. (Sub. Res. 703, I-93; Reaffirmation

A-01; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 704, A-12; Reaffirmed in lieu of Res. 714, A-14; Reaffirmed in lieu of Res. 814, I-14)

H-450.988 Guidelines for Quality Assurance
The AMA believes that the following guidelines should be utilized in any medical peer review system: (1) The general policies and processes to be utilized in any quality assurance system should be developed and concurred with by the professionals whose performance will be scrutinized, and should be objectively and impartially administered. (2) Any remedial quality assurance activity related to an individual practitioner should be triggered by concern for that individual's overall practice patterns, rather than by deviation from specified criteria in single cases. (3) The institution of any remedial activity should be preceded by discussion with the practitioner involved. (4) Emphasis should be placed on education and modification of unacceptable practice patterns rather than on sanctions. (5) The quality assurance system should make available the appropriate educational resources needed to effect desired practice modifications. (6) Feedback mechanisms should be established to monitor and document needed changes in practice patterns. (7) Restrictions or disciplinary actions should be imposed on those practitioners not responsive to remedial activities, whenever the appropriate professional peers deem such action necessary to protect the public. (8) The imposition of restrictions or discipline should be timely, consistent with due process.(9) Quality assurance systems should be structured and operated so as to assure immunity for practitioners conducting or applying such systems who are acting in good faith. (10) To the degree possible, quality assurance systems should be structured to recognize care of high quality as well as correcting instances of deficient practice. (CMS Rep. C, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-450.970 Quality Management Principles
Our AMA (1) continues to support the concept that physicians and healthcare organizations should strive continuously to improve the quality of health care; (2) encourages the ongoing evaluation of continuous quality improvement models; (3) promotes implementation of effective quality improvement models; and (4) identifies the useful approaches for assisting physicians in implementing quality improvement procedures in their medical practices and office management. (BOT Rep. AA, A-92; Reaffirmed: CMS Rep. 9, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-450.982 Patient Satisfaction and Quality of Care
Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality. (CMS Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed BOT Rep. 9, A-13)

H-450.949 Update on Patient Safety
Our AMA: (1) asserts that quality improvement programs must always consider patient safety when selecting their objectives; and (2) encourages all physicians to become familiar with and capitalize on opportunities to use technology to ensure patient safety in prescribing medications and medical devices. (BOT Rep. 13, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

H-450.973 Outcomes Research
1. It is the policy of the AMA to (a) continue to promote outcomes research as an effective mechanism to improve the quality of medical care, (b) urge that the results of outcomes research be used for educational purposes and not as part of punitive processes, (c) promote the use of outcomes research in the development of practice parameters, (d) advocate that findings of outcomes research which identify individual physicians should only be disclosed within formal peer review processes, and (e) monitor outcomes research activities of the federal government, research organizations, and others. 2. The AMA urges state medical societies, national medical specialty societies, hospital medical staffs, and individual physicians to (a) assist organizations in the planning, development, implementation, and evaluation of appropriate outcomes research, (b) identify the significance and limitations of the findings of outcomes research, and (c) ensure that outcomes research is conducted in a manner that protects the confidentiality of patients and physicians. 3. The AMA urges organizations conducting or planning to conduct outcomes research to (a) ensure the accuracy of the data used in outcomes research, (b) include relevant physician organizations and practicing physicians in all phases of outcomes research, including the planning, development, implementation, and evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of outcomes research, and (d) ensure that outcomes research is conducted in a manner that maintains patient and physician confidentiality. (BOT Rep. K, A-91; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)

H-450.932 Public Reporting of Quality and Outcomes for Physician-Led Team-Based Care
1. Our AMA will advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level. 2. Our AMA will advocate that public reporting of quality and outcomes data for team-based care should be done at the group/system/facility level, and not at the level of the individual physician. 3. Our AMA reaffirms the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA 2008) that public reporting of quality and outcomes data for team-based care should be done at the group/system level, and not at the level of the individual physician. 4. Our AMA will advocate that the current regulatory framework of public reporting for Meaningful Use also provide "group-level reporting" for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis. (Res. 734, A-14)

H-450.999 Practice Evaluation
(1) Our AMA urges state and local medical societies to consider developing public information programs to inform consumers about existing quality assurance activities. (2) Our AMA encourages increased use of office or hospital outpatient facilities, and use of these facilities for diagnostic testing prior to hospitalization whenever medically feasible, and where quality of service can be assured. (BOT Rep. II, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10)

21. DE-LINKAGE OF MEDICAL STAFF PRIVILEGES FROM HOSPITAL EMPLOYMENT CONTRACTS (RESOLUTION 820-I-15)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-225.950 and D-225.975

At its 2015 Interim Meeting, the House of Delegates referred Resolution 820-I-15, De-Linkage of Medical Staff Privileges from Hospital Employment Contracts, to the Board of Trustees for report. Resolution 820, which was introduced by the Florida Delegation, asked our AMA to:

> study and take appropriate action, up to and including pursuing Federal legislation, to statutorily de-link/ uncouple medical staff privileges from physician employment contracts, and report back to the House of Delegates at the 2016 Interim Meeting.

DISCUSSION

The termination of an employment agreement can substantially disrupt a physician's practice, especially when that termination carries with it automatic rescission of the physician's hospital medical staff membership and/or clinical privileges. In these situations, the physician may have no option but to relocate to another community if he or she wishes to resume any kind of practice that requires access to hospital facilities. Such circumstances may be especially vexing for a physician seeking to transition from employment to independent practice without uprooting his or her professional and personal lives.

AMA policy generally opposes linkage of medical staff membership and/or clinical privileges to an employment agreement. The AMA advocates instead that medical staff membership or privileges held during the term of employment should be rescinded only when an independent action of the medical staff calls for such action, and after the physician has been afforded full due process under the medical staff bylaws or, where the reason for termination is non-clinical or not otherwise a concern of the medical staff, under the employer's human resources policies and procedures (AMA Policy H-225.950—see in particular sections 3.e. and 5.f.) (See Appendix).

At the same time, AMA policy recognizes that there are in fact situations in which physicians reasonably may be expected to resign their medical staff membership and privileges upon termination of their employment agreements. The AMA views automatic resignation of membership/privileges acceptable so long as:

1. The contract was for the provision of services on an exclusive basis (i.e., the medical staff is closed);

2. The hospital's decision to terminate the exclusive contract is subject to medical staff review, and interested parties—including the physician/group—are provided an opportunity to comment on the decision; and

3. This consequence of termination is clearly stated in the agreement (AMA Policies H-225.950 and H-225.985).

Surrender of membership/privileges in this manner is common practice when a physician or his or her group has entered into a co-management or service line agreement with the hospital, or, more broadly, when the medical staff is otherwise closed. For this reason, it is infeasible to wholly "de-link/uncouple medical staff privileges from physician employment contracts," as advocated by Resolution 820.

While it may not be possible to separate medical staff membership and privileges from employment contracts in all cases, the AMA has developed a variety of resources, outlined below, to address the core issues raised by automatic rescission of medical staff membership and privileges—namely that such action denies physicians the due process protections guaranteed by the medical staff bylaws and makes it exceedingly difficult for physicians to exit employment altogether and enter or re-enter independent practice, should they so desire.

Model employment agreement

A physician's first line of defense against automatic rescission of privileges following termination of an employment agreement is the inclusion of protective language in his or her contract. Accordingly, the AMA has developed the following model language for insertion into physician-hospital employment agreements:

> Sample "Effect of Termination" Provision
> Upon termination, Physician shall retain full Medical Staff membership and clinical privileges as he or she held during the term of this Agreement and nothing herein shall adversely affect Physician's Medical Staff membership or clinical privileges or require Physician to resign the same, unless an independent action by the Medical Staff has called for the same, and Physician has been afforded full due process under the Medical Staff Bylaws.
>
> Sample "Due Process" Provision
> In the event of termination of this Agreement by Employer for any reason [or, alternatively: In the event of termination of this Agreement by Employer for cause related, directly or indirectly, to Physician's professional competence or conduct or for economic reasons (including, but not limited to, quality/performance improvement, patient safety, or other protocols)], Physician shall have the full and un-waivable right to notice and a fair hearing before a hearing body and otherwise afforded meaningful due process protections [in accordance with Employer's fair hearing plan as proscribed in its Medical Staff Bylaws or related Medical Staff documents, such as the Medical Staff Fair Hearing Plan].[1]

Model state legislation

Recognizing that physicians may lack the power to successfully negotiate the insertion of protective language into their employment agreements, the AMA has developed model state legislation that would require hospitals to provide due process for employed physicians. Specifically, this legislation would require hospitals to provide the following due process protections prior to terminating a physician's employment, medical staff membership, or clinical privileges, either "for cause" or "without cause":[2]

- Specific notice of the proposed termination;
- An unbiased, fair hearing of at least three physicians;
- Right to be represented by an attorney;
- Access to evidence;
- Ability to call and cross examine witnesses; and
- Appeal rights.

Model medical staff bylaws

Finally, appropriately crafted medical staff bylaws may provide additional protection for employed physicians upon termination of their employment contracts, particularly in those states in which bylaws have been found to establish contractual obligations between physicians and the hospital.[*] To that end, the AMA has developed the following sample provision for inclusion in hospital medical staff bylaws:

[*] Approximately one-half of the states have held that medical staff bylaws always constitute a contract between the hospital and the medical staff (a contract *per se*) or that the bylaws may be binding and enforceable on the hospital and the medical staff so long as key contractual elements are present. Only eight states have explicitly held that bylaws do not constitute a contract.

Sample Bylaw: Hearing Rights for Employed Physicians

Medical Staff membership, privileges, and hearing and appeal rights granted under these bylaws are not subject to waiver by employment contract or otherwise between [hospital/health care entity] and other parties. A medical staff member providing professional services under a contract with the hospital shall not have medical staff privileges terminated for reasons pertaining to the quality of care provided by the medical staff member without the same rights of hearing and appeal as are available to all members of the medical staff.[3]

CONCLUSION

As a general principle, employed physicians should not be required to automatically resign their medical staff membership and/or privileges following the termination of an employment agreement. Rather, these prerogatives should be rescinded only after the physician has been afforded full due process under the medical staff bylaws or, where the reason for termination is non-clinical or not otherwise a concern of the medical staff, under the employer's human resources policies and procedures. The universal application of this principle is complicated by the existence of circumstances under which a physician may reasonably be expected to resign his or her medical staff membership and privileges following the termination of an employment agreement—namely, in cases of closed medical staffs. As a result, it is infeasible to entirely disconnect medical staff membership and privileges from employment contracts.

Nevertheless, our AMA can alleviate the negative consequences of such linkage by taking steps to ensure that medical staff membership and privileges are *automatically* rescinded only under the narrowest of circumstances, and that in all other cases, medical staff membership and privileges are rescinded only after the physician has been afforded full due process. Existing AMA policy reinforces this principle. More importantly, the AMA has developed a variety of resources to help physicians exiting employment agreements retain their right to due process protections before termination of their medical staff membership or clinical privileges. As more physicians seek to transition from hospital employment to independent practice, it is imperative that the AMA continue its work in this area.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 820-I-15, and that the remainder of this report be filed:

1. That American Medical Association Policy H-225.950, AMA Principles for Physician Employment, be reaffirmed.

2. That our American Medical Association develop resources to assist physicians transitioning from employment to independent practice.

REFERENCES

1 AMA Annotated Model Physician-Hospital Employment Agreement (2012), available for free to AMA members ($149 for non-members) at www.ama-assn.org/go/employment.
2 Two separate pieces of model state legislation—entitled "Act to Provide Due Process Protection Concerning For Cause Terminations" and "Act to Provide Due Process Protection Concerning Without Cause Terminations"–are available to AMA members upon request from the Advocacy Resource Center (arc@ama-assn.org).
3 AMA Physician's Guide to Medical Staff Organization Bylaws, Sixth Edition (2015), available for free to AMA members ($149 for non-members) at www.ama-assn.org/go/bylaws.

Appendix - Related AMA Policy

H-225.950 AMA Principles for Physician Employment

1. Addressing Conflicts of Interest
   a. A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
   b. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the

independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

c. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
    ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e. Assuming a title or position that may remove a physician from direct patient-physician relationships–such as medical director, vice president for medical affairs, etc.–does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
    b. Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
    c. When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
    d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
    e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
    f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
    g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
   a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
   b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
   c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
   d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations
   a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
   b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
   c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians–not lay administrators–should be ultimately responsible for all peer review of medical services provided by employed physicians.
   d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
   e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
   f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
      i. The agreement is for the provision of services on an exclusive basis; and
      ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
      iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
   a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual

payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association. (BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14)

H-225.985 Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract
The AMA believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.(Res. 182, A-87; Res. 806, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

22. STUDY OTC AVAILABILITY OF NALOXONE (RESOLUTION 909-I-15)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-95.932 and D-95.987

INTRODUCTION

At the 2015 Interim Meeting, the House of Delegates referred Resolution 909-I-15, "Study OTC Availability of Naloxone," introduced by the Medical Student Section, which asked:

> That our AMA encourage manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration; and
>
> That our AMA study and report back at A-16 on ways to expand the access and use of naloxone to prevent opioid-related overdose deaths.

Reference Committee testimony broadly supported increasing access to naloxone to help prevent morbidity and mortality from opioid-related overdoses. This testimony highlighted current ways in which naloxone is available to patients and third parties, including through the use of standing orders and collaborative practice agreements. The Reference Committee noted that re-classifying naloxone as an over-the-counter (OTC) medication would require a sponsor to conduct a study and submit an application to the US Food and Drug Administration (FDA) demonstrating that naloxone can be used safely and effectively in the OTC setting. Some members of the Reference Committee expressed concern that OTC access might reduce the ability for a patient to receive education and counseling, although the OTC approval process would require a showing that consumers can accurately decide if the medication is indicated, understand the medication label, and successfully administer the medication.

This report focuses on the second clause of Resolution 909-I-15, that our AMA study and report back on ways to expand the access and use of naloxone. It provides a brief history of naloxone use in the United States, an update on ways in which patients and third parties are currently able to access naloxone, and information regarding ways in which that access can be increased. It recommends that existing AMA policy regarding improving access to naloxone be reaffirmed and that new recommendations be adopted.

BACKGROUND

The United States is in the midst of an opioid overdose epidemic. Rates of overdose mortality have increased by nearly 600 percent since 1980, and overdose is now the leading cause of injury death in the United States. Although this rise was initially caused primarily by opioid analgesics, the last few years have seen sharply increasing mortality rates due to heroin overdose, exacerbated in part by the addition of fentanyl to heroin supplies.

Naloxone, a pure opioid antagonist, was approved by the FDA in 1971. It has been used for decades in emergency health care settings to reverse opioid-induced respiratory depression, sedation, and hypotension. It has no potential for abuse. Many organizations support increased access for naloxone, including the American Pharmacists Association, the US Conference of Mayors, the National Governors Association, the federal Office of National Drug Control Policy, the American Public Health Association, the Harm Reduction Coalition (HRC), the National Association of State Alcohol/Drug Abuse Directors, the American Association of Poison Control Centers, and state and local law enforcement and other organizations representing first responders.

Naloxone has also been made available by community-based organizations to people who use illicit drugs as well as their friends and families since the mid-1990s.[1] The HRC found that, from 1996 through June 2014, community-based organizations distributed more than 150,000 naloxone reversal kits and received reports of more than 26,000 overdose reversals.[2] Most of these initial programs operated without clear legal authority, limiting their impact. The past few years have seen a rapid expansion in laws designed to increase access to naloxone, which has permitted these programs to grow in size and scope. Although the provision of naloxone through pharmacies is quickly becoming mainstream and there are now nearly daily reports in local newspapers around the country about overdose reversals from parents, friends and bystanders, the majority of naloxone in the United States is still dispensed through community and governmental organizations.

While governmental agencies like health departments in many areas now dispense naloxone, increased access has been seen in other agencies as well. For example, law enforcement agencies in more than 30 states currently are authorized to carry and administer naloxone.[3] These agencies have reported more than 2,400 lives saved to date. To help support further law enforcement uptake, the US Bureau of Justice Assistance has created a "Law Enforcement Naloxone Toolkit[4]" that provides resources on administering naloxone, liability and risk, and acquiring naloxone aimed at the law enforcement community.

There are four forms of naloxone generally used in outpatient settings in the United States: intramuscular using a traditional syringe; intranasal using a syringe with attached nasal applicator; and two recently approved products–a nasal spray (brand name Narcan™) and an intramuscular auto-injector (brand name Evzio™). The first two are the least expensive and have been the most widely used, responsible for tens of thousands of outpatient overdose reversals to date. The two newer products have only begun to be used in the community and by law enforcement, but have already resulted in hundreds of successful overdose reversals.[5]

Increasing demand for outpatient naloxone has coincided with price increases and questions about whether health plans will include the newer forms of naloxone on their formularies with affordable cost-sharing. A detailed analysis of cost issues is beyond the scope of this report, but we would be remiss if we failed to highlight the importance of ensuring that all forms of naloxone are financially accessible to patients at risk of overdose and, where permitted by law, the friends and family members of those patients. While several state attorneys general earned important concessions from naloxone manufacturers to control costs in recent years, it is important to ensure that patients have access to the formulation that they and their physician have decided is the most appropriate for them.

Despite price increases, new research shows that there has been a great increase in naloxone dispensed by pharmacies over the past 18 months. Specifically, there has been a 1,170 percent increase in naloxone dispensed by pharmacies from the fourth quarter of 2013 to the second quarter of 2015.[6] While the report found that "most naloxone in the community continues to be distributed through community-based programs," it highlighted the dramatic increase in naloxone prescribed and dispensed by health care professionals. The report also notes that there is much work yet to be done in this area: in the second quarter of 2015, pharmacies dispensed only 4,291 units of naloxone nationwide.

Some of the reasons for the low number of prescriptions can be found in qualitative research from Kaiser Permanente, Denver Health Medical Center, and University of Colorado School of Medicine.[7] In 10 focus groups

comprising 56 clinicians, feedback was obtained on "attitudes about prescribing naloxone to patients also taking opioids prescribed for pain at internal medicine, family medicine, and HIV clinics." The authors found that, on one hand, "[c]linicians commonly expressed beliefs that naloxone could effectively prevent overdose deaths. Prescribing the drug may increase patient understanding of the risks associated with opioid use." Yet, "[o]nly three of the 37 clinicians with prescribing authority had prescribed naloxone." Some of the reasons clinicians reported for not co-prescribing naloxone included time constraints, not wanting to offend patients, and not knowing whether providing naloxone would lead to "riskier" behavior.

Due to changes in state laws and actions taken by a number of pharmacy chains designed to increase access to naloxone, it is likely that the number of naloxone units dispensed via pharmacies is significantly higher now. In 2015, CVS announced[8] that it would begin providing naloxone via standing orders and collaborative practice agreements through its pharmacies, so that patients, and, in states where laws permit, third parties can access naloxone without first receiving a prescription. In 2016, Walgreens[9] and Kroger[10] announced that they, too, would begin making naloxone available at their pharmacies without patient-specific prescriptions. In total, these pharmacy policies will increase access to naloxone in more than 35 states.

Pharmacists also may dispense naloxone pursuant to a collaborative drug therapy protocol supervised by a physician. This behind-the-counter access approach provides pharmacists the opportunity to educate the recipient on how to identify and respond to an opioid overdose, and in some cases, on options for the treatment of opioid use disorder. This type of education has proved successful in the community setting and takes advantage of the training and expertise of the pharmacist working in conjunction with a physician's supervision or standing order protocol.

Although not a replacement for naloxone co-prescribed to an individual patient, these innovations have strong support and have seen widespread adoption. As the Network for Public Health Law reports:

> Approximately 30 states now permit naloxone to be prescribed via standing order, which allows it to be dispensed to any person who meets criteria specified by the prescriber without the prescriber and the patient ever meeting. Four states (CT, ID, ND and NM) permit pharmacists to prescribe naloxone, and around a dozen permit pharmacists to dispense the medication under a collaborative practice agreement with a physician. Still other states permit pharmacists to dispense the medication under a protocol created by one or more licensing boards, which essentially serves as a statewide standing order. In all of these cases, the medication is still technically dispensed via prescription.

Our AMA Task Force to Reduce Opioid Abuse (Task Force) also has made increasing access to naloxone a key recommendation to help save lives from overdose. Last year, our AMA and many of the organizations in the Task Force joined the Obama Administration in committing to increasing access to naloxone to help save lives from overdose.[11] The Task Force recommends that physicians consider co-prescribing naloxone to patients at risk of overdose. In addition to supporting state legislative policy, our Task Force has developed a handout[12] that identifies several factors that may be helpful for physicians in determining whether to co-prescribe naloxone to a patient, or to a family member or close friend of a patient at risk for overdose. There are many benefits to co-prescribing including the patient and physician having the opportunity to discuss risks of overdose, appropriate use of opioids, safe storage and disposal of unused medication, and normalizing the discussion about risk of overdose and reducing the stigma associated with risk of overdose, and where appropriate and clinically indicated, having a substance use disorder.

In its co-prescribing recommendations, the Task Force did not distinguish which form of naloxone should be used. Rather, that decision is best left to the physician and the patient and would be determined by many factors including the patient's comfort level with using a needle and syringe to pull the correct dose from the vial; the patient's financial circumstances; whether an intramuscular or nasal route is the best option; and other considerations. While our AMA was pleased to see FDA approve the two new formulations of naloxone, it also is clear that formulations most commonly used in the community and by many in law enforcement (e.g. needle/syringe, nasal applicator) have saved tens of thousands of lives in the community and should not be limited by guidelines, legislation or other policies.

It is also beyond the scope of this report to identify all other sites where increased access to naloxone may be beneficial, but it is clear from the literature that a few high-risk areas merit particular attention. Most importantly, individuals who currently abuse opioids or who may re-start opioids after a period of abstinence are at extremely

high risk of overdose. As such it is imperative that overdose prevention education and naloxone provision be incorporated into protocols for individuals leaving correctional facilities and abstinence-based treatment programs. One manufacturer already has partnered with the Clinton Health Matters Initiative to provide naloxone in all US schools,[13] and there are discussions to have naloxone available on college campuses and other public areas where an overdose might occur. Other manufacturers also have generously donated their products to law enforcement agencies and community organizations. We applaud these efforts.

Finally, our AMA appreciates that there may be liability concerns among physicians and other health care professionals as well as law enforcement and others who may prescribe, administer, or dispense naloxone. There is no evidence, however, that shows the concerns have been realized in the form of increased liability or actual suits against physicians or others for acts or omissions related to naloxone. That said, it is consistent with our AMA policy to support the concept that a health care professional who is authorized to prescribe or dispense an opioid antagonist shall not be subject to any disciplinary action or civil or criminal liability for the prescribing or dispensing of an opioid antagonist to a person whom the health care professional reasonably believes may be in a position to assist or administer the opioid antagonist to a person at risk for an opioid-related drug overdose.

AMA POLICY

AMA Policy currently is limited to D-95.987, "Prevention of Opioid Overdose," which states:

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 909-I-15, and that the remainder of the report be filed. [Editor's note: Resolution 909-I-15 had in fact been adopted; see Policy D-95.974.]

1. That our American Medical Association reaffirm Policy D-95.987, "Prevention of Opioid Overdose."

2. That our AMA support legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

3. That our AMA support efforts that enable law enforcement agencies to carry and administer naloxone.

4. That our AMA encourage physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.

5. That our AMA encourage private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing. and

6. That our AMA support liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.

7. That our AMA support efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.

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23. REMOVING FINANCIAL BARRIERS TO PARTICIPATION IN CLINICAL TRIALS FOR MEDICARE BENEFICIARIES AND H.R. 6, 21ST CENTURY CURES ACT (RESOLUTIONS 813 AND 823-I-15)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FILED (BOARD ACTION AFFIRMED)

INTRODUCTION

At the 2015 Interim Meeting of the House of Delegates (HOD), Resolutions 813-I-15, "Removing Financial Barriers to Participation in Clinical Trials for Medicare Beneficiaries," and 823-I-15, "H.R. 6 21st Century Cures Act," were referred for decision. Resolution 813-I-15, introduced by the Academy of Physicians in Clinical Research, asks our American Medical Association (AMA) to: advocate for legislation providing Medicare beneficiaries with coverage for the full amount of Medicare approved expenses incurred through participation in approved clinical trials by:

(a) requiring Medicare to pay 100 percent of all of a beneficiary's Medicare approved costs of routine care and care for complications associated with approved clinical trials and not paid by Medicare or, if this proves unfeasible, a combination of b. and c. below;
(b) removing Medicare provisions that prohibit clinical trial sponsors from covering Medicare copays and deductibles; and/or

(c) requiring all Medigap supplement insurance policies to pay all of a beneficiary's Medicare approved costs of routine care and care for complications associated with approved clinical trials and not paid by Medicare or clinical trials sponsors.

Resolution 823-I-15, introduced by the Georgia Delegation, asks our AMA to:

(a) advocate for the US Senate to amend H.R. 6, 21st Century Cures Act to prohibit all supplemental (Medigap) insurance policies (Parts B, C, and D) from denying coverage of the entire Medicare approved expenses for a FDA approved clinical trial that Medicare Part A does not cover; and/or
(b) advocate that the legislation be amended to allow sponsors of clinical trials to cover what supplemental insurance does not for those beneficiaries with supplemental insurance, as well as what supplemental insurance would have covered for those Medicare beneficiaries without Part B or Part C and/or Part D supplemental insurance or that in cases of Medicare and FDA approved clinical trials, Medicare be required to pay 100 percent of all Medicare approved expenses.

The HOD supported referral for decision of Resolutions 813-I-15 and 823-I-15 because the issue of clinical trial insurance coverage is multi-pronged and complex. In addition, it was noted that possible ethical considerations could be raised as payment could be viewed as coercion to participate. It was further noted that the US Senate Health, Education, Labor and Pension (HELP) Committee was considering the issue of clinical trial coverage in early January 2016 and that, given the complexity and time-sensitive nature of the issue, the Board should report its decision to the HOD at the 2016 Annual Meeting.

AMA POLICY

Current AMA Policy H-460.965 Viability of Clinical Research Coverages and Reimbursement provides that:

…(1) third party payers should cover patient care costs of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms; (2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision-making processes; (3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated; (4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;…(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well-being of the American people; and (10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system. (CSA Rep. F, I-89; Reaffirmed: Joint CMS/CSA Rep., I-92; Reaffirmed: BOT Rep.40, I-93; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 4, A-02; Reaffirmed: CMS Rep. 4, A-12). (H-460.965 Viability of Clinical Research Coverages and Reimbursement.)

DISCUSSION

In 2010, the National Academy of Science published a report, the *National Cancer Clinical Trials System for the 21st Century* (NAS Report), which focused on clinical trials in the oncology arena, but also contains findings and recommendations about participation rates in clinical trials among US patients that apply across disease states. For a host of reasons outlined in the NAS Report, participation in clinical trials is the exception rather than the rule both for patients and for physicians. The low rates of participation are particularly troubling in the oncology space because new therapies increasingly are targeted and require larger numbers of patients willing to participate in clinical trials, since these trials are based on stratified populations. Our AMA has long-standing and strong support of public funding of clinical trials as well as coverage of patient care costs by third-party payers to advance the clinical evidence base, H-460.965, Viability of Clinical Research Coverages and Reimbursement. While industry has played an important translational role, singular reliance on the private sector to support clinical trials is problematic as certain comparative research of great benefit could be neglected because of limited return on investment for manufacturers and increasingly industry is moving clinical trials overseas.

One of the factors that undermine the participation of patients and treating physicians in clinical trials is the confusion and requirements related to third party insurance coverage of routine care, care needed as a result of complications of clinical trials, and copay/coinsurance/deductibles. The NAS Report not only identifies the barriers in the Medicare program (including Part B contractor variability, Medicare Advantage and Medicare Part D policies), but also identifies the full scope of private and public payer coverage/co-pay/co-insurance/deductible policies that generate confusion and uncertainty that deter patient participation in clinical trials.

The Board concluded both Resolutions 813-I-15 and 823-I-15 raise legitimate and well-documented concerns with regard to coverage and co-pays/co-insurance/deductibles policies that undermine patient willingness to participate in clinical trials as well as federal policies that limit the ability of clinical trial sponsors to cover such costs for certain beneficiaries in certain federal health care programs such as Medicare. However, both Resolutions too narrowly define the scope of advocacy required and the scope of clinical trials that should be eligible for coverage. Therefore, the Board adopted modifications to policy H-460.965 that preserves our AMA's ability to advocate vigorously consistent with both resolutions as part of the ongoing congressional legislative efforts to advance clinical research.

In lieu of adopting Resolutions 813-I-15 and 823-I-15, the Board modified Policy H-460.965, Viability of Clinical Research Coverages and Reimbursement, to read as follows:

> Our AMA believes that: (1) legislation and regulatory reform should be pursued to mandate third party payers should coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms; (2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision-making processes; (3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated; (4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;…(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well-being of the American people; and (10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and (11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/co-insurance/deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials.

This modification ensures that while our AMA is directed to engage in advocacy, the efforts are not limited to only the Medicare program and FDA related clinical trials. This also ensured that our AMA has been positioned to advocate consistent with Resolutions 813-I-15 and 823-I-15 as part of the HELP Committee's consideration of legislative proposals that parallel H.R. 6, the "21st Century Act of 2015," which has passed in the US House of Representatives.

To that end, our AMA has submitted letters to the US Senate HELP Committee and the US House of Representatives Committee on Energy and Commerce urging Congress to support innovation and participation in clinical trials by incorporating third-party payer coverage in federal health care programs of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved clinical tests. In addition, our AMA similarly submitted a letter to the Obama Administration encouraging the President to ensure that the Precision Medicine Initiative (PMI) promotes such comprehensive coverage, utilizing existing flexibilities, for those who participate in the PMI clinical research.

24. IOM "DYING IN AMERICA" REPORT (RESOLUTION 6-I-15)

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At its 2015 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred to the Board of Trustees Resolution 6-I-15, "IOM 'Dying in America' Report," introduced by the Medical Association of Georgia. Resolution 6 asked our AMA to "support and advocate for the recommendations of the Institute of Medicine 'Dying in America' report, which will improve the quality of end-of-life care received by all patients."

Testimony for this resolution supported the spirit of the IOM report in light of the recognized need to improve quality of care at the end of life. However, testimony noted that AMA had not had an opportunity to vet the report thoroughly in light of existing AMA policies on relevant issues and noted that endorsing the report in its entirety could have unintended consequences for AMA.

The overarching goal of *Dying in America* is to ensure that all patients "with advanced serious illness who are nearing the end of life" have round-the-clock access to comprehensive care provided by appropriately trained personnel in appropriate settings, in keeping with individuals' values, goals, and preferences. The report identifies five key domains in which action is needed: financing for comprehensive care; quality measurement; professional education, licensure, and credentialing; interoperable electronic health records; and public education about end-of-life care and advance care planning. In each of these areas, the report recommends specific activities and defines accountability among key stakeholders.

The House of Delegates requested that a report be presented to the HOD at its 2016 Annual Meeting. However, to ensure sufficient opportunity to carefully review the recommendations of the Institute of Medicine in light of extensive AMA policy in the areas noted above the Board of Trustees will submit its final report at the 2016 Interim Meeting.

25. AMA POLICY ON DIRECT TO CONSUMER ADVERTISING

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

By adopting the 1st resolve of Substitute Resolution 927-I-15, the House of Delegates (HOD) established Policy H-105.986, "Ban Direct-to-Consumer Advertisements of Prescription Drugs and Implantable Medical Devices," which directs our American Medical Association (AMA) to support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

The 2nd resolve of Substitute Resolution 927-I-15 asked that Policy H-105.988, "Direct-to-Consumer Advertising of Prescription Drugs and Implantable Medical Devices" be rescinded. Policy H-105.988 contains a detailed set of guidelines for establishing what the AMA would consider to be acceptable product-specific direct to consumer advertisements (DTCA) for prescription drugs, as long as this practice is considered legal and protected free speech in the US. In referring the 2nd resolve for decision, the HOD asked the Board of Trustees (BOT) to determine whether it was still advisable to maintain a set of detailed requirements for such advertisements from the industry, given that our policy is to support an outright ban on the practice.

In evaluating this issue, the BOT discussed that while our current policy supports a ban on DTCA, it may be reasonable and prudent to maintain a policy that provides a framework to evaluate the appropriateness and/or usefulness of DTCA. This is based principally on the fact that the Supreme Court has ruled that DTCA is protected free speech; therefore, this practice will continue and perhaps increase in the future.

The BOT also notes that the current policy evolved over a 15-year period and has not been re-examined in any detail for more than a decade. Because of the contentious nature of the issue, the potential impact of DTCA on consumer

drug costs, and other concerns specific to the policy, the BOT agreed that a full report evaluating the policy in a contemporary fashion is advisable. Accordingly, Policy H-105.988 is retained in its current form, pending development of a full report to the HOD at the 2016 Interim Meeting.

26. DEMOGRAPHIC REPORT OF THE HOUSE OF DELEGATES AND AMA MEMBERSHIP

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

This informational report, "Demographic Report of the House of Delegates and AMA Membership," is prepared pursuant to Policy G-600.035, "House of Delegates Demographic Report," which states:

> A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

In addition, this report includes information pursuant to Policy G-635.125, "AMA Membership Demographics," which states:

> Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

This document compares the House of Delegates (HOD) with the entire American Medical Association (AMA) membership and with the overall United States physician and medical student population. Medical students are included in all references to the total physician population throughout this report to remain consistent with the bi-annual Council on Long Range Planning and Development report. In addition, residents and fellows endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA-HOD includes both delegates and alternate delegates.

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2015 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2015 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 540 allotted at the 2015 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 940 rather than the 1,080 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 16% of AMA members and approximately 20.5% of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of AMA Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA membership and delegates along with corresponding figures for the entire physician and medical student population.

Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2015

2015	AMA Members	All Physicians & Medical Students	AMA Delegates & Alternate Delegates[1],[2]
Total	234,360	1,260,301	940
Mean age (years)[3]	47.7	51.4	55.3
Age Distribution (percent)			
Under age 40	47.36%	29.70%	17.13%
40-49 years	10.93%	19.16%	11.70%
50-59 years	12.12%	18.77%	24.04%
60-69 years	11.37%	16.67%	33.19%
70 or more	18.22%	15.70%	13.94%
Gender (percent)			
Male	66.49%	66.46%	75.43%
Female	33.47%	33.45%	24.57%
Unknown	0.04%	0.09%	0.00%
Race/Ethnicity (percent)			
White non-Hispanic	57.60%	52.75%	71.81%
Black non-Hispanic	4.62%	4.12%	3.83%
Hispanic	4.91%	5.24%	3.09%
Asian/Asian American	14.69%	15.11%	8.40%
Native American	0.34%	0.25%	0.21%
Other[4]	1.76%	2.05%	1.38%
Unknown	16.07%	20.48%	11.28%
Education (percent)			
US or Canada	83.38%	76.99%	91.70%
IMG	16.62%	23.01%	8.30%

Data on physicians' and students' current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

[1] There were 140 vacancies as of year's end, most of which are unfilled alternate delegate slots.
[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3] Age as of December 31. Mean age is the arithmetic average.
[4] Includes other self-reported racial and ethnic groups.

Table 2. Life Stage, Present Employment and Self-Designated Specialty[5], December 2015

2013	AMA Members	All Physicians & Medical Students	AMA Delegates & Alternate Delegates
Life Stage (percent)			
Student[6]	23.73%	7.19%	6.28%
Resident[6]	19.10%	10.91%	6.06%
Young (under 40 or first 8 years in practice)	9.44%	18.61%	7.23%
Established (40-64)	24.62%	40.19%	52.55%
Senior (65+)	23.11%	23.10%	27.87%
Present Employment (percent)			
Self-employed solo practice	9.54%	9.76%	15.74%
Two physician practice	1.94%	1.95%	2.77%
Group practice	24.97%	41.04%	39.04%
HMO	0.11%	0.19%	0.74%
Medical school	1.35%	1.81%	5.74%
Non-government hospital	2.34%	2.80%	5.43%
State or local government hospital	5.01%	7.11%	9.04%
US government	1.37%	2.33%	4.26%
Locum Tenens	0.22%	0.21%	0.11%
Retired/Inactive	9.53%	10.35%	4.15%
Resident/Intern/Fellow	19.10%	10.91%	6.06%
Student	23.73%	7.19%	6.28%
Other/Unknown	0.81%	4.35%	0.64%
Specialty (percent)			
Family Medicine	9.03%	11.93%	11.06%
Internal Medicine	18.67%	23.09%	20.21%
Surgery	14.40%	13.70%	22.23%
Pediatrics	4.89%	8.79%	3.72%
OB/GYN	5.57%	4.81%	5.96%
Radiology	3.58%	4.54%	5.64%
Psychiatry	3.77%	5.35%	5.11%
Anesthesiology	3.66%	4.73%	3.62%
Pathology	1.73%	2.28%	1.91%
Other specialty	10.99%	13.58%	14.26%
Students	23.73%	7.19%	6.28%

Appendix - Specialty classification using physician's self-designated specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery

[5] See Appendix A for a listing of specialty classifications.
[6] Students and residents are categorized without regard to age.

Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

27. NOMINATION FOR AND IMPROVEMENT OF THE POSITION OF THE UNITED STATES SURGEON GENERAL (RESOLUTION 204-A-15)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-440.929

INTRODUCTION

At the 2015 Annual Meeting, the House of Delegates (HOD) referred Resolution 204-A-15, "Nomination for and Improvement of the Position of the United States Surgeon General," for a report back at the 2016 Annual Meeting. This resolution, introduced by Medical Society of Delaware asked that:

> Whenever there is a vacancy in the position of the United States Surgeon General, the American Medical Association Council on Science and Public Health provide the names of three individuals for consideration to the American Medical Association (AMA) Candidate Review Committee for approval, after which the names will be forwarded to the AMA Board of Trustees (BOT) for final consideration. The individuals' names and credentials will then be submitted by the AMA BOT to the President of the United States through the appropriate submission procedures for consideration of appointment to the position of United States Surgeon General, with final approval by the United States Senate; and that our AMA BOT appoint a task force comprised of former Surgeons General of the United States and other leaders within the public health community to consider how the position of United States Surgeon General can be strengthened to better advocate for the health of the citizens of the United States; and be it further
>
> RESOLVED, That the findings of that task force be forwarded to the AMA Council on Legislation for the purpose of having it draft legislation that, upon approval of the AMA BOT, can be brought forward to the United States Congress for passage into law with the anticipation that improvement in the overall function of the Office of the United States Surgeon General can be achieved and, therefore, result in fewer vacancies in the position of United States Surgeon General.

DISCUSSION

The Surgeon General of the United States Public Health Service is appointed by the President of the United States and requires Senate confirmation. Every Administration has a series of senior officials in each department whom the President appoints. Within the Department of Health and Human Services (HHS) there are a number of Presidential appointees who play a significant role on health issues. Some of the senior Presidential appointments at the HHS include: the Administrator for the Agency for Healthcare Research and Quality (AHRQ), Assistant Secretary for Health (ASH), Director of the Centers for Disease Control and Prevention (CDC), Administrator of the Centers for Medicare & Medicaid Services (CMS), Commissioner for the Food and Drug Administration (FDA), Administrator

for the Health Resources and Services Administration (HRSA), Director of the National Institutes of Health (NIH), and the Surgeon General of the United States Public Health Service.

The United States Surgeon General's principal role is to supervise the Public Health Service Corps activities and to advise the ASH on policies required for efficient management of the commissioned corps and other matters. In addition, as the "Nation's Doctor," the Surgeon General provides Americans with information on how to improve their health and reduce the risk of illness and injury.

The authors of Resolution 204-A-15 cite concerns that during the Ebola crisis the nation lacked a health spokesperson to minister to the health of our citizens. Within the Obama administration, the responsibility for responding to the Ebola epidemic was housed with the Director of CDC, Thomas Frieden, MD. Part of CDC's mission is to deal with outbreaks both domestically and internationally. CDC also houses the clinical resources and national public health reporting mechanisms required to identify, monitor and respond to epidemics. In a crisis like Ebola, the Director of CDC will always play a central role. Consequently, during the Ebola outbreak, there was a physician in a leadership role in the administration with the necessary resources and knowledge base who was accountable for coordinating the federal government's response and communicating to the public about the crisis. In addition, Dr. Frieden was supported by Anthony Fauci, MD, Director of the National Institute of Allergy and Infectious Disease. That said, if a confirmed Surgeon General had been in place it may have helped the Administration with its education efforts.

The AMA's HOD established a process the AMA must follow before endorsing nominees for federal positions. HOD policy requires that both the AMA's Candidate Selection Committee as well as the AMA's BOT must consider potential candidates for federal appointments. The current process is time-consuming and resource intensive. Resolution 204-A-15 would add further complexity to the process by calling for the Council of Science and Public Health (CSAPH) to submit three United States Surgeon General candidates to the Candidate Selection Committee.

This process raises a question as to whether our organization would support an individual nominated by the President who was not among those recommended by the AMA. This may put the AMA in an awkward position with a new Administration, which in turn may negatively affect our ability to influence other issues of importance to medicine.

Resolution 204-A-15 also calls on the AMA to appoint a task force of former Surgeons General to consider how to strengthen the Office of Surgeon General. Such a task force would require a significant amount of AMA resources to implement with little promise for return on this investment.

The upcoming Presidential election presents a unique opportunity to raise these issues. Historically the incoming Administration will examine all types of management issues during the transition period. The AMA always engages the Presidential Transition Team. We will do so again this year. In our discussions with the Transition Team, we recommend that we raise the issue of the role of the Surgeon General and resources allocated to the office.

RECOMMENDATION

The Board of Trustees recommends adoption of the following recommendation in lieu of Resolution 204-A-15:

> That our American Medical Association convey to the Presidential Transition Team support for an enhanced role for the Surgeon General in addressing important matters of public health.

28. 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 professional interest medical association and specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2016 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 and AMA Bylaw 8.5.

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.

The following organizations were reviewed for the 2016 Annual Meeting:

AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Child and Adolescent Psychiatry
American Association of Clinical Endocrinologists
American Association of Hip and Knee Surgeons
American Association of Physicians of Indian Origin
American College of Medical Genetics and Genomics
American College of Radiation Oncology
American Institute of Ultrasound in Medicine
American Orthopaedic Foot and Ankle Society
American Society for Clinical Pathology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Hematology
American Society of Neuroimaging
American Society of Neuroradiology
International Society of Hair Restoration Surgery
Obesity Medicine Association
Renal Physicians Association
Society of Critical Care Medicine
Society of Interventional Radiology

The American Society of Hematology and the International Society of Hair Restoration Surgery were reviewed at this time because they failed to meet the requirements of the review in 2015.

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: AMDA – The Society for Post-Acute and Long-Term Care Medicine, Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society

of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, and the Society of Critical Care Medicine meet all guidelines and are 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 AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, and the Society of Critical Care Medicine retain representation in the American Medical Association House of Delegates.

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, American Association of Clinical Endocrinologists, American Association of Hip and Knee Surgeons, American Society of Neuroimaging and the Society of Interventional Radiology be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

3. Having failed to meet the requirements of 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 Society of Hematology and the International Society of Hair Restoration Surgery not retain representation in the House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
AMDA - The Society for Post-Acute and Long-Term Care Medicine	853 of 3,840 (22%)
American Academy of Child and Adolescent Psychiatry	1,408 of 8,373 (17%)
American Association of Clinical Endocrinologists	778 of 4,649 (17%)
American Association of Hip and Knee Surgeons	356 of 1,976 (18%)
American Association of Physicians of Indian Origin	1,145 of 7,188 (16%)
American College of Medical Genetics and Genomics	347 of 735 (47%)
American College of Radiation Oncology	316 of 1,024 (31%)
American Institute of Ultrasound in Medicine	1,174 of 5,273 (22%)
American Orthopaedic Foot and Ankle Society	218 of 1,023 (20%)
American Society for Clinical Pathology	2,094 of 10,138 (20%)
American Society of Anesthesiologists	5,958 of 36,901 (16%)
American Society of Cataract and Refractive Surgery	1,085 of 5,108 (21%)
American Society of Colon and Rectal Surgeons	225 of 1,132 (20%)
American Society of Hematology	828 of 5,159 (16%)
American Society of Neuroimaging	87 of 295 (30%)
American Society of Neuroradiology	464 of 2,383 (20%)
International Society of Hair Restoration Surgery	89 of 302 (30%)
Obesity Medicine Association	253 of 1,299 (20%)
Renal Physicians Association	568 of 2,142 (27%)
Society of Critical Care Medicine	1,539 of 9,224 (17%)
Society of Interventional Radiology	564 of 3,299 (17%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020) and Professional Interest Medical Associations (G-600.022)

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.

Policy G-600.022

1. Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):
   (a) the organization must not be in conflict with the Constitution and Bylaws of our AMA;
   (b) the organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association);
   (c) the organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the 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 our AMA; or (iii) that the organization 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 our AMA;
   (d) the organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application;
   (e) physicians should comprise the majority of the voting membership of the organization;
   (f) 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;
   (g) the organization must be active within the profession, and hold at least one meeting of its members per year;
   (h) the organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states;
   (i) the organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization; and

(j) if international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.

2. The process by which PIMAs seek admission to the House of Delegates includes the following steps:
   (a) a PIMA will first apply for membership in the Specialty and Service Society (SSS);
   (b) using specific criteria, SSS will evaluate the application of the PIMA and, if the organization meets the criteria, will admit the organization into SSS;
   (c) after three years of participation in SSS, a PIMA may apply for representation in our AMA House of Delegates;
   (d) SSS will evaluate the application of the PIMA, determine if the association meets the criteria for representation in our AMA House of Delegates, and send its recommendation to our AMA Board of Trustees;
   (e) the Board of Trustees will recommend to the House how the application of the PIMA should be handled;
   (f) the House will determine whether or not to seat the PIMA; and
   (g) if the application of a PIMA for a seat in the House is rejected, the association can continue to participate in SSS as long as it continues to meet the criteria for participation in SSS.

Exhibit C – Responsibilities of Specialty Societies and Professional Interest Medical Associations

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.

8.6 Discontinuance of Representation. A specialty society or a professional interest medical association that has been granted representation in the House of Delegates will automatically have its representation terminated if it is not represented by a properly certified and seated delegate at 3 of 5 consecutive meetings of the House of Delegates. The specialty society or the professional interest medical association may continue as a member of the SSS pursuant to the provisions of the Standing Rules of the SSS, and may apply for representation in the House of Delegates after 3 additional years as a member of the SSS, under all of the provisions for a new application.

REPORTS OF THE SPEAKERS

The following reports, 1–2, were 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
Recommended actions accomplished

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." Insofar as our AMA has more than 3,800 current policy statements (not including ethical opinions), your speakers believe that such housekeeping is a necessary exercise.

While the focus of this report is on policies affected by actions taken in 2015, pursuing such policies also revealed policies that contained dated requests for reports that have previously been provided. Thus, in addition to the more recently affected policies, minor changes to other policies are also made below (see items 6 and 7), and all references to the JCAHO or the Joint Commission on the Accreditation of Healthcare Organizations will be updated to The Joint Commission.

As an aside, your speakers would also use this opportunity to remind members of the House that a new version of PolicyFinder was released after November's Interim Meeting. The new version is more intuitive, employs a more robust search engine and offers several options for capturing policy language. Comments on PolicyFinder are welcome and should be sent to hod@ama-assn.org. Likewise, that address may be used to report other policy statements thought to be outdated or needing revision for any other reason.

RECOMMENDED RECONCILIATIONS

Policies to be Rescinded in full

1. Board of Trustees Report 7-I-15, "Employee Associations and Collective Bargaining for Physicians," responded to Policy D-383.981, which will be rescinded.

   D-383.981, Employee Associations and Collective Bargaining for Physicians
   Our AMA will study and report back on physician unionization in the United States

2. The Council on Medical Service prepared CMS Report 2-A-15, "Physician Payment by Medicare," in fulfillment of Policy D-285.964, which will therefore be rescinded.

   D-285.964, Physician Payment by Medicare
   Our AMA will study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice.

   Worth noting are two related reports that the Council on Medical Service had also prepared to the House of Delegates: CMS Report 3-A-13, "Payment Parity across Outpatient Sites of Service," and CMS Report 3-A-14, "Medicare Update Formulas across Outpatient Sites of Service." An advocacy briefing document available on the Council on Medical Service website (ama-assn.org/go/cms) reflects the AMA policy established with the adoption of these reports.

3. Council on Medical Service Report 7-A-15, "Physician Access to ACO Participation," responded to the directive of Policy D-160.930, rendering that policy unneeded; it will be rescinded.

D-160.930, Studying Physician Access to ACO Participation
Our AMA will study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (c) the implications of such criteria and processes for patient access to care outside the ACO; and (d) the effect of evolving system alignments and integration on physician recruitment and retention. The results of this study will be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting.

Outdated References to be Deleted from Policy Statements

The following changes will delete only the references to reports and not reset the sunset clock.

4. Policy D-405.988, The Preservation of the Private Practice of Medicine, includes a request for a report at the 2015 Annual Meeting, which was met with Board of Trustees Report 16-A-15, "Progress Report for the Private Practice of Medicine." That specific request for a report is to be rescinded.

   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.

5. Section 2 of Policy D-120.943, Review of Straddle Drug Pricing Rules for Medicare Part D Participants, will be stricken as it was satisfied by Board of Trustees Report 20-A-15, "Review of Straddle Drug Pricing Rules for Medicare Part D Participants."

   D-120.943, Review of Straddle Drug Pricing Rules for Medicare Part D Participants
   Our AMA: (1) urges the Centers for Medicare and Medicaid Services (CMS) to examine how Medicare Part D plans are applying the straddle drug pricing rules and determine whether costs are being inappropriately shifted to beneficiaries whose drug spending totals span multiple coverage phases~~; and (2) will prepare a report explaining the straddle drug pricing rules and their potential impact on patients, incorporating information that is available from CMS regarding implementation by Part D plans~~.

6. When Policy D-255.993, J-1 Visas and Waivers, was initially adopted, it included a request for a report back at the 2003 Annual Meeting, which was satisfied by Board of Trustees Report 10-A-03, "J-1 Visa Waivers." Policy D-255.993 was reaffirmed in 2014, but the portion calling for the requested report will be deleted. Aside from the specific report, that section is also addressed by the more recent Policy D-255.985, which is quoted below.

   D-255.993, J-1 Visas and Waivers
   1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program. 2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program. 3. ~~Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad 30 programs with a report back at A-03. 4.~~ Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area. 5.

Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

D-255.985, Conrad 30 – J-1 Visa Waivers
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program. 2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program. 3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs. 4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses. 5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

7. Policy D-35.984, Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy, called for the development of principles regarding the use imaging during invasive procedures. Board of Trustees Report 16-A-13 developed the requested principles, which are found in Policy H-410.950. The portion of the policy calling for the report will be rescinded.

D-35.984, Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy
1. Our AMA will (a) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians, and (b) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy. ~~2. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.~~

Correcting References to The Joint Commission

A number of policy statements include references to the former name of The Joint Commission. The following policies will be updated to reference "The Joint Commission" rather than "Joint Commission on the Accreditation of Healthcare Organizations" or "JCAHO." No other changes will be made to these policies and the sunset clock will not reset. (This list does not include policies such as Policy H-280.953, which are addressed in various sunset reports at this meeting.)

- D-155.998, Meeting with Business Coalitions
- D-235.990, JCAHO Standard MS.1.20
- H-210.991, The Education of Physicians in Home Care
- H-220.933, Critical Relevancy of Medical Staff in JCAHO Standards
- H-220.966, Future Directions of the JCAHO
- H-220.971, Joint Commission Medical Staff Standard on the Amendment of Bylaws
- H-220.988, Hospital Admitting Privileges
- H-220.996, Private Patients and the Responsibility of the Attending Physician in a Teaching Hospital Setting
- H-230.986, JCAHO Recognition of Specialty Boards Recognized by American Board of Medical Specialties and AMA and AOA

- H-235.980, Hospital Medical Staff Self-Governance
- H-310.999, Guidelines for Housestaff Contracts or Agreements
- H-455.993, Treatment of Radiation Accident Victims
- H-480.968, Telemedicine

The changes outlined above will be implemented when this report is filed.

2. PROCEDURES OF THE HOUSE OF DELEGATES

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-600.054

At the 2015 Annual Meeting, the House of Delegates adopted Resolution 2, amending American Medical Association (AMA) bylaws to name the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* [hereinafter AIP] as the parliamentary authority for AMA meetings. That section of the bylaws states:

> 11.1Parliamentary Procedure. In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*.

Our AMA's prior parliamentary authority was Alice Sturgis's *The Standard Code of Parliamentary Procedure* (4th Edition) [hereinafter Sturgis], which became effective starting with the 2004 Annual Meeting. The procedures described by AIP and Sturgis are remarkably similar.[1] The first House of Delegates (HOD) meeting conducted under AIP was this past November's 2015 Interim Meeting in Atlanta. While your Speakers had offered an overview of salient differences between AIP and Sturgis before I-15 commenced, few delegates were able to attend, and plans to make relevant points about AIP during the meeting were confounded by extended debate on procedural matters during Sunday's second opening when items were accepted as business by the House.

The combination of a new parliamentary authority and discomfort among some members of the House following the procedural debate on Sunday led your Speakers to form the Speakers' Advisory Committee to study the AIP, with an eye to ensuring that AIP meets our AMA's needs. Members of the committee were Patricia Austin, Mark Bair, Corey Howard, Kristina Novick, David Rosman, Gary Thal and Bruce Scott, who served as chair. Your Speaker, Susan Bailey, also participated, ex officio. Members' affiliations are listed in the Appendix. The committee was given the following charge:

> Study and assess the alignment of the *House of Delegates Reference Manual* (November 2014 edition) with the current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* and recommend changes to the Manual, including any changes in procedure, policies or practices of the HOD.

The recommendations made below stem from the committee's deliberations as well as communication from interested members of the House and consultation with one of the authors of AIP where language in the volume was open to interpretation. In addition, your Speakers have endeavored to retain those elements that have characterized our House of Delegates meetings over the years, supporting changes only as appropriate.

PROCEDURES OF OUR HOUSE OF DELEGATES

Our AMA's House of Delegates meetings are conducted by a combination of tradition, provisions in AMA's bylaws, rulings from the speaker and our parliamentary authority. Until 2005 HOD procedures were maintained in a 12-page document titled simply "Procedures of the House of Delegates." The preface of that earlier document, which was prepared by several prior speakers, noted that "No rigid codification of [House of Delegates] rules exists…. The majority of the House in determining what it wants to do and how it wants to do it should always

remain the ultimate determinant. It is the obligation of the Speaker to sense this will of the House [and] to preside accordingly."

Our traditions—what some might characterize as standing rules—are generally captured in the *House of Delegates Reference Manual: Procedures, Policies and Practices* [hereinafter Reference Manual], which is maintained by the Council on Constitution and Bylaws and available on the website of the Office of House of Delegates Affairs (ama-assn.org/go/hod).[2]

Parliamentary Procedure and the House of Delegates

As noted, under the bylaws our House of Delegates meetings are governed by our AMA's parliamentary authority, now AIP. By and large, differences between AIP and the prior parliamentary authority, Sturgis, are relatively minor, with most changes dealing with terminology rather than changes in actual procedures. Longtime members of the House may also recall that prior to Sturgis, our AMA's parliamentary authority was James E. Davis's *Rules of Order* [hereinafter Davis]; Davis covered meetings starting with the 1992 Interim Meeting and extending through the 2003 Interim Meeting.[3] It was replaced by Sturgis after going out of print. Dr. Davis was vice speaker (1981–1984), speaker (1984–1987) and president (1988–1989) of our AMA.

Quoting from AIP, "The purpose of parliamentary procedure is to facilitate the orderly transaction of business and to promote cooperation and harmony…. Parliamentary law makes it easier for people to work together effectively … [and] should not be used to awe, entangle, or confuse the uninitiated" (AIP, p. 2). Very nearly the identical language appears in Sturgis (p. 7).

Davis expresses the same sentiment, wherein it states, "Parliamentary procedure is not the stilted, ritualized system that allows those who know it best to take advantage of their less knowledgeable colleagues. To the contrary, parliamentary procedure is the great leveler that assures protection and equal access to all members. It guarantees that the playing field remains level for all" (p. 4).

HOD Traditions

Parliamentary law allows an organization to develop its own rules, rules that do not fully comport with the parliamentary authority. The idea is that organizations are dynamic and will change and adapt over time. For example, AIP offers that "Organizations sometimes adopt rules of procedure that add to or vary from the rules of parliamentary law as stated in their parliamentary authority" (p. 245). Thus our AMA can adopt rules that best suit the character and operation of our House of Delegates.

An example of special rules employed by our House is the tradition of hearing both sides prior to closing debate on a topic. Regarding a motion to close debate and vote immediately, only Davis required both sides of the question to have been heard before the motion was in order. Although neither Sturgis nor AIP has such a requirement, the tradition has been maintained. Another example is separate motions to refer for report and refer for decision. Although Dr. Davis made them distinct motions, likely because of his experience with the House of Delegates, AIP and Sturgis simply state that the maker of a motion to refer should include relevant provisions as part of the motion, so for example, a motion intended to refer an item for decision would include the provision that the body to which an item is referred would have the authority to act on behalf of the organization. Because all referrals from the HOD are directed to the Board of Trustees, the body is implicit in a motion to refer for decision under our procedures. (See the discussion below, p. 143.)

ADVISORY COMMITTEE ACTIVITY

The Speakers' Advisory Committee was so named as it was assembled precisely to render advice to your Speakers. Committee members and your Speakers exchanged multiple emails and met once face-to-face to reach consensus on the following motions that are addressed in AIP:

- Motion to Table
- Motion to Adopt in-lieu-of
- Motion to Refer to Committee
- Motion to Recall from Committee

The following additional subjects were also discussed because they affect the way our HOD operates:

- Amendment by substitution (covered under the motion to amend in AIP)
- Emergency and late resolutions

Motion to Table

In Atlanta at I-15 the extended procedural debate during the second session of the HOD on Sunday morning was sparked by a motion to table a resolution. It is during the second session that all items of business, including both reports and resolutions, are accepted as business of the House and then, with the exception of informational reports and memorial resolutions, referred to the reference committees for hearings.

Introduction of business

Because it is relevant to the discussion below, we should be clear how and when proposals are actually accepted as business. For both reports and resolutions, the procedure is comparable, although they are handled separately. Reports come first in the order of business, and the speaker will note that they have been distributed and state that "absent objection" they will be accepted as business and referred to the indicated reference committees.[4] (It seems unlikely that a delegate would ever object to accepting a board or council report as business of the House.) Immediately thereafter focus turns to informational reports, and the speaker asks for extractions; extracted reports are sent to a reference committee, and the others are filed when the speaker asks for a motion to file the remaining reports. Filing simply indicates that the House has received the information but has taken no action on a particular item, nothing more.

After the informational reports have been dealt with, the speaker reads the names of individuals for whom memorial resolutions have been received, and attention then turns to the resolutions. Again the speaker notes that the resolutions have been distributed "in the Handbook, the Addendum and the material received this morning" (i.e., the Sunday tote) and asks for a motion (and second) to accept the resolutions as business of the House. (During the Interim Meeting, the next step deals with resolutions recommended against consideration by the Resolution Committee.)

Thus the procedure is precise in how and when business is accepted. Upon acceptance items become the property of the House, and up to that point the sponsor of an item can withdraw the item from consideration, but after the assembly has accepted the item, permission is required for withdrawal. Hence the need for the House to grant "leave to withdraw" (AIP, p. 97) occasionally arises.

Right of the House to determine its business

A foundational tenet of every deliberative body is the right to determine its business, that is, to accept or not accept as business proposals that come before it. Having accepted an item, the body may then deliberate on it and decide on a course of action. This is precisely why once an item has become the property of the assembly, the sponsor can no longer simply withdraw it but must gain the consent of the body to withdraw the item.

In our House of Delegates, any delegate has the freedom to propose a resolution on any topic, and the House has placed very few limits on submitted resolutions. Only two circumstances allow for a resolution to be declined at the time of submission. The first is a resolution seeking the endorsement of a screening test, which must be accompanied by an evidence-based review, the absence of which precludes acceptance of the resolution. The second is commendation resolutions, which are prohibited because of "potential for these resolutions to be controversial in nature and, because unanimous approval is assumed without debate, commendation resolutions may serve to embarrass the Association" (Reference Manual, p. 29). While most resolutions are submitted by delegations or groups, our procedures allow relatively unfiltered access for any other resolution submitted for a House meeting and included in the meeting Handbook, although some circumstances may mean the resolution is not actually considered (e.g., non-advocacy resolutions at the Interim Meeting).

Your Speakers recognize the utmost importance of freedom of speech and protecting the right of the minority to be heard. There must be some balance between these rights and the will of the assembly to control its business. Our House has many times voiced a desire to focus our deliberations, and our rules call for courtesy, respect and

collegial conduct. While we hope the occasion would never occur, we can envision resolutions that the House may elect not to discuss because of the scurrilous or irrelevant nature of the resolution. In addition, there may be instances when debate (pro and con) or a vote (up or down) may be embarrassing to an individual or the association. The unfiltered open access of our House demands some mechanism for the assembly to object to consideration of an item, and our tradition of protecting the minority voice demands that this mechanism require a high hurdle.

Retain the motion to table

Although the motion to table an item can be seen as a threat to free speech or an effort to suppress debate, it is more accurately the body exercising its collective right to determine its business, and while use of the motion at I-15 surprised many, the motion has been available under every parliamentary authority used by our AMA. Under both Sturgis and Davis, the motion was to "postpone temporarily." The intent of the motion was vague—was the motion intended to delay debate until a later time perhaps when more information or an individual would be available to help the assembly deliberate the issue more effectively or was the intent to postpone until the assembly adjourned, rendering the main motion moot? Under Sturgis, the presiding officer was to attempt to determine the intent of the maker, and if the intent was to suppress a main motion without debate, a two-thirds majority was required to adopt the motion to postpone; in other circumstances a simple majority was sufficient. Under Davis, no such clarification was prescribed, and only a simple majority was required.

The motion, though the name may have changed, has long been part of our HOD procedures, albeit one rarely offered. The committee favors retaining the motion to table, and your Speakers agree. Given the right of any delegate to submit a resolution on any topic at any meeting, the House should have the right to decide that a particular item of business does not merit consideration. The motion carries with it safeguards to prevent its misuse or overuse. Consider that under AIP a successful motion to table requires a two-thirds majority without debate. The committee specifically considered whether debate of the motion to table should be allowed (AIP does not allow debate of the motion to table) and concluded that the fact that the motion is not debatable actually makes passage more difficult. Under such circumstances it must be plainly apparent to a supermajority of the assembly that a proposal is so offensive, unreasonable or outside the scope of normal business that discussion is unwarranted. In addition, the committee thought it counterintuitive to allow debate on whether a topic should be debated. While your Speakers could attempt to limit debate to the merits of tabling, these efforts would likely be confounded by delegates slipping into debate on the resolution.

Moreover, normal practice within the House of Delegates means that the item will have received some consideration and discussion in many venues, including any number of caucuses and the online forum. Insofar as multiple caucuses meet before Sunday's second session of the House, it is simply incorrect to say that an item has been given no consideration.

In addition, a motion to table ought not be considered disparaging of the resolution or its sponsor. The motion may also avoid discussion of a potentially embarrassing situation, for example, a member's grossly inappropriate behavior or an effort to heap praise on an individual, which will be an invitation for negative commentary from some quarters.

Timing of the motion to table

The committee further considered whether the motion to table should be permitted after the item has been accepted as business but before it has been discussed in a reference committee or only after the reference committee hearing. Under AIP the motion is in order at any time, and the committee's position is that our HOD meetings are best served by maintaining that rule. As noted above, the House has the right to determine its business, and given the general absence of restrictions on proposals, the House should retain the right not to discuss an item and to dispose of it without further consideration.

Bear in mind that the motion must be adopted by a two-thirds supermajority and without debate, meaning the item in question must be so obviously inappropriate that two-thirds (or more) of members wish to dispose of it without discussion. With no possibility to dispose of such business, the House is subject to the tyranny of a minority of one.

Offering the motion after business has been accepted but before the reference committees meet is nothing more than an objection to consideration. In fact, if a delegate wishes to object to consideration, the appropriate motion is to

"table" the item. This motion has been in use by the HOD under at least our last three parliamentary authorities. Most recently it was referred to as a motion to "postpone temporarily" as described in the Reference Manual (p. 40):

> After resolutions are presented and accepted by the House, a motion to postpone temporarily is in order if a delegate wishes to prevent further action on an item. This might occur if an item is considered objectionable by a delegate. The motion must be sustained by a two-thirds vote.

The earlier "Procedures of the House of Delegates" included the same provision.

Because the motion to table (or its functional equivalent, the motion to postpone temporarily) has always been part of the HOD's procedures, and despite its rarity of use, the motion should be retained. Neither your Speakers nor the committee anticipate a flurry of inappropriate resolutions, but to disallow the motion prior to reference committee hearings would foreclose an option that may be necessary for orderly and transparent House operation.

Under AIP, the motion to table is not renewable and may not be reconsidered. However, the underlying motion (i.e., the motion that was "tabled") may be reconsidered through the usual "motion to reconsider," which is a main motion. Limited debate on the reason(s) to reconsider is allowed, but debate on the underlying motion itself would be "out of order." The motion to reconsider requires only a majority vote. While passage of a motion to table a main motion removes all pending amendments as well as the main motion, reconsideration, if successful, returns only the main motion, with any amendments that had been adopted prior to the motion to table, but amendments that were pending at the time the main motion was tabled do not return.

Finally, although this discussion has focused on the motion to table prior to reference committee hearings—because such a situation led in part to forming the committee—it should be noted that the motion to table is in order at any time and is the highest subsidiary motion that can be applied to a main motion. For example, during consideration of an item in a reference committee report it may become clear that the assembly is best served by disposing of the item without further debate or a formal vote. In other words, the motion to table is in order from the point at which an item has been accepted for business to the time that the House has taken final action on that item (subject of course to the underlying item being before the House). At the time of acceptance, it amounts to an objection to further consideration; thereafter, it would simply dispose of the item. In any case, the two-thirds vote without debate is required. The motion to table may not be recommended by the reference committee, because the motion is not debatable, and it would be inappropriate for the reference committee to explain the logic for the motion without allowing contrary debate. The recommendations available to reference committee are specified in the Reference Manual.

Motion to Adopt in-lieu-of

The AIP also incorporates the motion to "adopt in-lieu-of," which has long been practice with the House of Delegates. It is touched upon in the Reference Manual in the context of the reaffirmation calendar and substitute resolutions. It is now formalized within our parliamentary authority rather than a special rule. The motion to "adopt in-lieu-of" would arise in two situations, both of which would be main motions from the reference committee.

The more straightforward application of the motion would arise in the case where the reference committee recommends the adoption of one item in-lieu-of additional items being considered at the same meeting. For example, a report dealing with some matter may come to an HOD meeting along with a resolution(s) on a related topic, in which case the recommendations in the report might be adopted, possibly as amended, in lieu of the resolution(s). Likewise, a resolution might be adopted in-lieu-of one or more additional resolutions.

AIP also allows the use of the motion to "adopt in-lieu-of" from the reference committee to dispose of one or more resolutions. In the HOD this would have historically meant that the reference committee would propose a substitute resolution, and that substitute might be in place of a single resolution (e.g., Substitute 123 in lieu of Resolution 123) or in lieu of several resolutions (e.g., Substitute 123 in lieu of Resolutions 123, 124 and 125). However, the motion to "adopt in-lieu-of" is not a substitute under AIP (also see below, p. 144, "amendment by substitution"). Rather the motion offers entirely new language to replace one or more items. Thus, the reference committee may propose alternative language for a single resolution or propose some entirely new wording to replace multiple resolutions. In either case the reference committee will propose a main motion using the following form:

> Madam Speaker, your reference committee recommends that the following resolution be adopted in lieu of Resolution 123 [Resolutions 123, 124 and 125]:
>
> RESOLVED, That our AMA do such and so; [and be it further
>
> RESOLVED, That our AMA do this and that…]

Language in square brackets would appear as required by circumstances.

Under AIP the motion to "adopt in-lieu-of" is a main motion, subject to first and second order amendments like any other main motion. If the motion to "adopt in-lieu-of" is adopted, it enacts the motion itself while simultaneously defeating the underlying motion or motions (i.e., resolution(s)). If it is defeated, the original item or items become business only if a member moves the adoption of one or more; none automatically becomes the item of business. If it were to be the case that no one moves an underlying resolution, all would be considered to have been defeated.

When a motion to "adopt in-lieu-of" is proffered and someone wishes to have an underlying resolution considered separately, a request for division of the question is in order. Ideally this will come before debate ensues on the motion to "adopt in-lieu-of," but that is not required so long as the request comes before the motion to "adopt in-lieu-of" is adopted. Following that vote, a motion to reconsider would be required.

The most significant difference between AIP and past practice in our HOD is that defeat of the motion to "adopt in-lieu-of" does not automatically bring an original item to the fore. In the event of such an occurrence in the HOD one can expect the speaker to invite a motion to consider a resolution that would have been addressed in the defeated recommendation to adopt in-lieu-of. The method advanced by the AIP and supported by the committee allows the assembly to select which, if any, of the original resolutions will be considered.

Motion to Refer to Committee

Mentioned earlier is the manner in which our HOD handles a motion to refer an item. Under AIP the motion is to "refer to committee," but the Speaker's Advisory Committee favors our historical usage and the distinct motions of "refer for report" and "refer for decision." While this distinction is not specified by AIP, it has served our House of Delegates well and allowed the will of the assembly to be clear. The motion to "refer for report" will continue to send the item to the Board of Trustees (or to an AMA council through the board) for study and report back to the House. The motion to "refer for decision" will continue to be used to allow the board to determine the appropriate course of action and proceed. Delegates may request a report back from the board, but even without this request the board will continue to report back to the House on the decision and the action that was taken.

In addition, your committee considered the order of precedence of the two motions for referral. Past speakers have employed variable precedence and recently considered the motions to have equal precedence. The committee and your Speakers believe that the House benefits from the procedural clarity offered by specified rank ordered precedence (i.e., which motion is in order at a given time). Accordingly, we recommend that the motion to "refer for decision" should be one rank higher than the motion to "refer for report." This method will allow the shift from a motion to refer for report to a motion to refer for decision but not vice versa. In other words, a motion to refer for decision would have to be defeated before a motion to refer for report would be in order. During debate on referral for decision, comments as to the reason to defeat the motion to allow a motion to refer for report would be in order. Because both motions to refer have a higher precedence than the underlying main motion, it is necessary to defeat the motion to refer in order to amend or otherwise act on that underlying main motion (i.e., the report recommendations or resolution). This has been our practice.

In the absence of a specific motion to refer for decision or report, a simple motion to "refer" will be interpreted as a motion to refer for report, and a motion to "refer for study" is equivalent to a motion to "refer for report" or the abbreviated "refer." A motion to refer for decision should be specifically stated. A motion to "refer for action" will mean the same as "refer for decision." In short the separate motions to refer for report and refer for decision should be retained as a special rule in our HOD, and refer for decision should have a higher order of precedence.

Motion to Recall from Committee

Under AIP a specific main motion is to "recall from committee," which would as the name implies recall an item that had previously been referred to a committee. The advisory committee discussed the motion and its potential role and concluded that the motion is of little practical utility in our House of Delegates. If during a particular House of Delegates meeting an individual or group wishes to "recall" an item that has been referred, a motion to reconsider the item would be in order and is certainly more familiar to members of the House. The motion to reconsider can be proposed at any time before the meeting adjourns and may be made by any delegate. Only a simple majority is required to reconsider the requested item.

The motion to reconsider must be made prior to adjournment because the conclusion of the meeting renders the actions taken during that meeting as final, and under our HOD's procedures all business has been disposed of. As such the motion to recall from committee would not be in order at a succeeding meeting. Rather the appropriate course at a future meeting would be to introduce a new resolution, which could be acted on even if a report dealing with the prior meeting's referred item is still pending. In fact, it is not uncommon for a resolution to be submitted on a matter currently under study by the board or a council.

Given our procedures, no harm comes from retaining the motion to recall from committee as found in AIP. However, once a given meeting has concluded, no item is subject to recall or reconsideration. The advisory committee concluded that eliminating the motion to "recall from committee" was not essential and therefore does not recommend deviating from AIP in this regard.

Amendment by Substitution

Your Speakers have observed that the handling of amendments by substitution has sometimes varied across meetings, and the adoption of AIP affords an opportunity to define a consistent practice for our House of Delegates. At its most basic, an amendment by substitution is simply one type of amendment similar to the motions to amend by addition, amend by deletion or amend by addition and deletion. It has been common in reference committee reports and therefore familiar to anyone attending an HOD meeting.

Critically, however, an amendment by substitution is a first-order amendment, subject only to second-order amendments. Thus when an amendment by substitution is proposed by a reference committee, further amendments (second order amendments) would need to be disposed of as they arise before additional changes can be proposed. By extension, a substitute proffered from the floor is also a first-order amendment. Your Speakers do not foresee problems with this approach and will assist in reaching the desired outcome.

Language to facilitate this course should also be incorporated into reference committee reports and instructions to the reference committees. As a general rule, reference committees will be encouraged to employ amendments by addition and deletion rather than by substitution. However, should the reference committee recommend the adoption of a substitute, it will be necessary to include a recommendation to adopt as amended, as is the case with an amendment by addition or deletion. Both the amendment by substitution and the motion to adopt in-lieu-of can arrive at the same result, but the former limits amendments and requires two steps while the latter can accomplish the same outcome in a single step.

Amendment by substitution reflects historical usage in the HOD. While the use of "substitute" language is not incorrect, an amendment by substitution will limit further amendments to the second order. Given the alternative motion to adopt in-lieu-of, the most likely use of substitute language would be to replace a single resolve within a multi-resolve resolution.

Emergency and Late Resolutions

Another item considered in detail by the committee concerns late and emergency resolutions. Under AMA bylaws regular business includes items submitted no later than 30 days prior to the commencement of a House of Delegates meeting, with exceptions for AMA sections and societies for which the policy making body adjourns in the five weeks before the HOD meeting. Late resolutions are those not meeting the definition of regular business but submitted "any time prior to the final day of a meeting" (Bylaw 2.11.3.1.3). Emergency resolutions are those submitted on the final day of a meeting.

In recent years, multiple HOD meetings have adjourned on the day prior to the scheduled adjournment (i.e., on Tuesday for the Annual Meeting and on Monday for the Interim Meeting). While such efficiency is a compliment to both the speakers and the House collectively, it muddies the definitions of late and emergency resolutions.

Late resolutions are referred to the Committee on Rules and Credentials, which recommends to the House that the late item be accepted or not accepted. Acceptance requires a two-thirds vote, although a simple majority is sufficient for final action on the item. Late resolutions are routinely handled during the second session (i.e., Sunday morning) of the HOD, and can then be referred to reference committee for consideration like other resolutions. Potentially problematic, however, is that under current bylaws late resolutions may be submitted after the reference committee hearings have concluded. Not only does this require that the Committee on Rules and Credentials be reassembled, but it necessitates that the item, if accepted for business, be processed in the House, without the benefit of a reference committee hearing. Under current bylaws emergency resolutions are reviewed by a reference committee (not the Committee on Rules and Credentials), which makes a recommendation to the House as to whether to accept as business. Curiously the vote to accept late resolutions for business (two-thirds supermajority) is higher than what is required to adopt the proposal (simple majority). Meanwhile emergency resolutions are accepted for business upon the recommendation of the reference committee but require a three-fourths supermajority to adopt.

The committee believes that establishing an unambiguous cut-off for defining late and emergency resolutions will be of obvious value. Reference committee hearings on a resolution are essential to the HOD process and should only be bypassed for emergency resolutions. Therefore the defining point favored here for late resolutions is recess of the first session of the House of Delegates; given current schedules, that is Saturday afternoon. This would define late resolutions as those received fewer than 30 days prior to the start of the HOD meeting but not later than recess of the opening session. The existing exceptions should be maintained. This would provide time for the Committee on Rules and Credentials to review a resolution and the reasons for its lateness and to present a recommendation to the House during the second session (i.e., Sunday morning). It would also ensure that the item can be considered by a reference committee. To be clear this change would define resolutions submitted after the opening session of the House has concluded as emergency resolutions.

In addition, the procedure for handling emergency resolutions (the current procedures for which are found in the bylaws §2.11.5.2) should be simplified and more parallel to the process for late resolutions, but continue to have a higher requirement for consideration. Because an emergency resolution may come at any time, even after members of the requisite committee have departed, they will be presented to the full House. These items should require a three-fourths supermajority to accept as business of the House but, like late resolutions, should require only a simple majority for adoption. As a general rule, the requirement for a three-fourths majority for adoption would be expected when an action binds future groups or is an exception to the usual procedural rules as in this case, but an ordinary AMA policy is subject to revision at any HOD meeting by a simple majority vote.

This is not an effort to redefine late resolutions as emergency resolutions. Over the last five years, only three or four late resolutions would have been affected, as items have historically been submitted before the Saturday session has recessed. Nor is this proposal meant to make it more difficult to propose business after a meeting has started. Because emergency resolutions must be processed without the benefit of a reference committee hearing, their acceptance should meet a higher hurdle. At the same time, a situation that is truly emergent and that requires action before the next meeting of the House of Delegates should generally be self-evident, presumably rendering the three-quarters vote largely a formality.

FINAL DISCUSSION

The Speakers' Advisory Committee has reviewed *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure* and compared the rules therein to usual practice in the House of Delegates and the *House of Delegates Reference Manual*, which is prepared by the Council on Constitution and Bylaws. Aside from a few details the procedures of our House of Delegates are in harmony with AIP.

In that light, few special rules are warranted. Additionally, the AIP has been adopted as the parliamentary authority by a number of other organizations represented in the House of Delegates. Given the widespread use of AIP, the committee also believes that changes for change sake would be unwise. It conceivably would be a source of confusion for both our AMA and those other members of the Federation using AIP, because despite nominal reliance on the same authority, actual procedures might differ across societies. Nothing in AIP is so far outside the

historical precedents of our House of Delegates that it should be done away with, although key elements of our particular adaptations should be retained. From the committee's review this would require altering the motion to refer to committee as laid out in AIP and retaining our tradition whereby both sides must have been heard before closing debate. Otherwise, ensuring correspondence between the Reference Manual and actual practice is all that is required.

RECOMMENDATIONS

Your Speakers acknowledge and are grateful for the work conducted by the Speaker's Advisory Committee.

In light of the committee's review, your Speakers recommend that the following recommendations be adopted and the remainder of the report filed:

1. That our American Medical Association reaffirm *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure* as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.

2. The rules and procedures of the House of Delegates will be amended as follows:
   a. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
   b. A motion is added to the House of Delegates Reference Manual, "Object to Consideration." If a delegate objects to consideration by our HOD, the correct motion is to "Object to Consideration." The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a three-fourths vote for passage. Debate is restricted to why the item should not be considered.

3. That the procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.

4. That the procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.

5. That the procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.

6. That late resolutions be defined as those submitted less than 30 days before the opening day of a House of Delegates meeting but before the opening session recesses and not meeting the definition of regular business, and that business submitted after the recess of the opening session be regarded as emergency business, subject to a three-fourths vote for acceptance as business.

7. That the Council on Constitution and Bylaws prepare bylaws amendments to effect the changes in definitions as well as handling of late resolutions and emergency business and as part of that effort consider whether some related elements currently in the bylaws would better exist in policy.

8. That the Council on Constitution and Bylaws, in consultation with the speakers, review the *House of Delegates Reference Manual* and revise it accordingly.

Notes:

1. The first edition of Sturgis was published in 1950, and the revised second edition appeared in 1966. Following Alice Sturgis's death, a committee of the American Institute of Parliamentarians prepared the third (1988) and fourth (2001) editions of Sturgis. While the AIP volume (2012) cannot be considered a fifth edition of Sturgis, its lineage makes clear why AIP and Sturgis are similar.

2. The standing rules of our House of Delegates are not compiled and labeled as such. Rather, the HOD Reference Manual addresses the "standing rules" in outlining the operation of HOD meetings. The use of the HOD Reference Manual as authoritative is addressed in the report of the Committee on Rules and Credentials during the opening session of HOD meetings.

3. From 1969 to 1992 the parliamentary authority was the second edition of Sturgis, and prior to that it was Robert's Rules of Order.

4. The initial reference to reports concerns only those that propose policy statements or actions to be taken by our AMA. Informational reports are handled separately immediately after these "action" reports.

Appendix - Members of the Speakers' Advisory Committee

Patricia L. Austin, MD	Delegate, California and member, Council on Constitution and Bylaws
Mark Bair, MD	Delegate, Utah
Corey L. Howard MD	Delegate, Florida
Kristina Novick, MD	Alternate Delegate, American Society of Clinical Oncology
David A. Rosman, MD, MBA	Delegate, Massachusetts
Gary D. Thal, MD	Delegate, American Society of Anesthesiologists
Bruce A. Scott, MD	Vice Speaker and Delegate, Kentucky
Susan R. Bailey, MD	Speaker and Delegate, Texas

Dr Scott served as chair of the committee.

Committee charge

Study and assess the alignment of the House of Delegates Reference Manual (November 2014 edition) with the current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* and recommend changes to the Manual, including any changes in procedure, policies or practices of the HOD.