AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee on Amendments to Constitution and Bylaws

Peter H. Rheinstein, MD, JD, MS, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 2 – New Specialty Organizations Representation in the House of Delegates

2. Board of Trustees Report 13 – Mergers of Secular and Religiously Affiliated Health Care Institutions and Their Impact on Patient Care and Access to Services

3. Board of Trustees Report 23 – Healthcare as a Human Right

4. Board of Trustees Report 24 – Appropriate Placement of Transgender Prisoners

5. Board of Trustees Report 26 – Revision of Researcher Certification and Institutional Review Board Protocols

6. Board of Trustees Report 46 – Specialty Society Representation in the House of Delegates – Five-Year Review

7. Council on Ethical and Judicial Affairs Report 1 – Competence, Self-Assessment and Self-Awareness

8. Council on Ethical and Judicial Affairs Report 2 – Mergers of Secular and Religiously Affiliated Health Care Institutions

9. Council on Ethical and Judicial Affairs Report 3 – Medical Tourism

10. Council on Ethical and Judicial Affairs Report 4 – Expanded Access to Investigational Therapies

11. Council on Ethical and Judicial Affairs Report 5 – Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish “Physician Assisted Suicide” and “Aid in Dying”

12. Resolution 001 – Discriminatory Policies that Create Inequities in Health Care

13. Resolution 007 – Oppose the Criminalization of Self-Induced Abortion

14. Resolution 016 – Utilization of "LGBTQ" in Relevant Past and Future AMA Policies

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

15. Resolution 002 – FMLA Equivalent for LGBT Workers

16. Resolution 003 – Proposing Consent for De-Identified Patient Information

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

17. Board of Trustees Report 25 – Recognition of Physician Orders for Life Sustaining Treatment Forms

18. Council on Constitution and Bylaws Report 1 – CCB Sunset Review of 2008 House Policies

19. Council on Ethical and Judicial Affairs Report 6 – CEJA's Sunset Review of 2008 House Policies

20. Resolution 004 – Patient-Reported Outcomes in Gender Confirmation Surgery

21. Resolution 005 – Decreasing Sex and Gender Disparities in Health Outcomes

22. Resolution 006 – Living Donor Protection Act of 2017 (HR 1270)
Resolution 012 – Costs to Kidney Donors

23. Resolution 008 – Health Care Rights of Pregnant Minors

24. Resolution 014 – Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms

25. Resolution 015 – Human Trafficking/Slavery Awareness

26. Resolution 018 – Discrimination Against Physicians by Patients

27. Resolution 019 – Study of Medical Study of Medical Student, Resident and Physician Suicide

28. Resolution 010 – Gender Equity in Compensation and Professional Advancement
Resolution 011 – Women Physician Workforce and Gender Gap in Earnings-Measures to Improve Equality
Resolution 020 – Advancing the Goal of Equal Pay for Women in Medicine
Resolution 021 – Taking Steps to Advance Gender Equity in Medicine

RECOMMENDED FOR REFERRAL

29. Resolution 013 – Opposing Surgical Sex Assignment of Infants with Differences of Sex Development

RECOMMENDED FOR NOT ADOPTION

30. Resolution 017 – Revised Mission Statement of the AMA

Note: Resolution 009 –Improving and Increasing Clarity and Consistency Among AMA Induced Abortion Policies was withdrawn.

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

RECOMMENDATION:

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

Board of Trustees Report 2 recommends that the American Rhinologic Society, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, North American Neuromodulation Society, and the North American Neuro-Ophthalmology, Society be granted representation in our AMA House of Delegates.

Your Reference Committee heard no testimony regarding Board of Trustees Report 02 and is confident in the decisions made by the Board of Trustees. Your Reference Committee therefore recommends that Board of Trustees Report 2 be adopted.

(2) BOARD OF TRUSTEES REPORT 13 - MERGERS OF SECULAR AND RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS AND THEIR IMPACT ON PATIENT CARE AND ACCESS TO SERVICES

RECOMMENDATION:

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

Board of Trustees Report 13 responds to D-140.956, “Religiously Affiliated Medical Facilities and the Impact on a Physician’s Ability to Provide Patient Centered Safe Care Services.” The report notes that secular-religious hospital mergers are increasing in America, fueled in part by the financial pressures placed on smaller, more rural, hospitals. Most religious hospitals in the U.S. are Catholic and are governed by the *Ethical and Religious Directives for Catholic Health Services* (ERDs). The report explains that ERDs can restrict access to certain services and have directly affected outcomes for at-risk female patients seeking reproductive care, LGBTQ patients seeking gender-affirming surgery, and patients seeking assisted suicide. Secular-religious mergers may also affect the terms of health insurance policies, potentially creating situations in which the only other health care facilities left in an area might not be covered under a plan, forcing patients to seek care from institutions with restricted services. The report concludes that the analysis provided fulfills Directive D-140.956, and recommends that the directive be rescinded.

Your Reference Committee heard limited but unanimously supportive testimony in support of this report, and therefore recommends that Board of Trustees Report 13 to be adopted.

(3) BOARD OF TRUSTEES REPORT 23 - HEALTHCARE AS A HUMAN RIGHT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 23 be adopted and that the remainder of the report be filed.

This report responds to Resolution 7-A-17, "Health Care as a Human Right", which asks that our AMA recognize that health care is a fundamental right, support the United Nations' Universal Declaration of Human Rights and its International Bill of Rights, and advocate for the U.S. remaining a member of the WHO. Principle IX of the *AMA Principles of Medical Ethics*, Opinion 11.1.1, "Defining Basic Health Care" and 11.1.4, "Financial Barriers to Health Care Access" of the *Code of Medical Ethics*, and House Policies H-160-987, "Access to Medical Care" and H-160.975, "Planning and Delivery of Health Care Services", already support the broad concept of access to health care. With regards to the UN Declaration, the report notes that House Policy H-250.986, "AMA and Public Health in Developing Countries" outlines a circumscribed strategy for AMA participation in international policy, and for this reason, our AMA does not take a position on international treaties like the UN Declaration of Human Rights. With regards to supporting the WHO, House Policies H-250.999, "World Health Organization", and H-250.992, "World Health Organization", already affirms our AMA's support of the WHO and the U.S.'s involvement with it. The report recommends that AMA Policies H-160.987, "Access to Medical Care;" H-160.975, "Planning and Delivery of Health Care Services;" H-250.986, "AMA and Public Health in Developing Countries;" H-250.992, "World Health Organization;" and H-250.999, "World Health Organization," be reaffirmed in lieu of Resolution 7-A-17.

Testimony was generally supportive of the recommendations in Board of Trustees Report 23. Multiple associations noted that they have policy stating health care is a human right, with which current AMA policy is consistent to varying degrees. Some testimony suggested that the report did not go far enough in recognizing health care as a human right. Your Reference Committee considered both viewpoints, and overall testimony reflected that existing House policy adequately supports the intention of ensuring that all people have access to a basic level of health care. Your Reference Committee recommends that Board of Trustees Report 23 be adopted.

(4) BOARD OF TRUSTEES REPORT 24 - APPROPRIATE PLACEMENT OF TRANSGENDER PRISONERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 24 be adopted and that the remainder of the report be filed.

This report responds to Resolution 15-A-17, "Appropriate Placement of Transgender Prisoners", which asks that our AMA establish policy to support the placement of transgender prisoners in facilities of their affirmed gender. Problems facing the safety of

transgender prisoners are well documented and severe. American prisons currently house inmates according to their birth sex rather than their affirmed gender, which generates increased violence against transgender prisoners. Attempts to reduce this violence often result in the "administrative segregation" of transgender inmates, which generally amounts to punitive solitary confinement. Policies that allow transgender inmates to be housed according to their affirmed gender have been found to be successful in reducing violence. Thus, this report recommends that our AMA support the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status; and support that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Your Reference Committee heard testimony in general support of the adoption of Board of Trustees Report 24. It was noted that the Board of Trustees provides a solid framework for this complex issue that could prove useful to prison systems. Testimony also noted that transgender prisoners are both incarcerated at disproportionately high rates and are often victims of violence, and that a federal position could act as a model for state and county prisons. Your Reference Committee recommends that Board of Trustees Report 24 be adopted.

(5) BOARD OF TRUSTEES REPORT 26 - REVISION OF RESEARCHER CERTIFICATION AND INSTITUTIONAL REVIEW BOARD PROTOCOLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 26 be adopted and that the remainder of the report be filed.

This report addresses Resolution 11-A-17, "Revision of Researcher Certification and Institutional Review Board (IRB) Protocols", which asked our AMA to study IRB protocols and create recommendations that would protect patients while permitting physicians to easily participate in the dissemination of medical knowledge. In the goal of conducting ethical research involving human participants, multiple federal regulations were created. Together, these regulations are known as the "Common Rule" and set basic standards for research oversight. However, there are recent criticisms that the Common Rule is ineffective and cumbersome. The DHHS 2011 review of the Common Rule resulted in a 2018 update, which included changes to streamline the oversight process. The report recommends that our AMA continue to support efforts to improve protections for human subjects of biomedical and behavioral research and advocate for change as opportunities arise.

Your Reference Committee heard testimony in general support of this report, noting that the report correctly focuses on the protection of patients. Other testimony noted that the report provides flexibility for our AMA to work with various agencies to address problems if and when they arise. Opposing testimony was offered by the author of Resolution 11-A-17, to which this report responded, who suggested that the report did not take into

consideration the needs of the researchers, who often find that compliance with the Common Rule to be complicated, burdensome and expensive. However, your Reference Committee agrees that patient protections should not be relaxed, and thus recommends that Board of Trustees Report 26 be adopted.

(6) BOARD OF TRUSTEES REPORT 46 - SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 46 be adopted and that the remainder of the report be filed.

Board of Trustees Report 46 recommends that the Academy of Physicians in Clinical Research, Aerospace Medical Association, American Academy of Dermatology Association, American Academy of Facial Plastic and Reconstructive Surgery Inc., American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association of Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American College of Medical Quality, American Society of Addiction Medicine, American Society of Echocardiography, American Society of General Surgeons, American Society of Ophthalmic Plastic and Reconstructive Surgery , GLMA: Health Professionals Advancing LGBT Equality, The Endocrine Society and, Spine Intervention Society retain representation in the American Medical Association House of Delegates.

Your Reference Committee heard no testimony opposing the adoption of Board of Trustees Report 46. Testimony was offered suggesting that the current system, under which large societies have proportionally fewer AMA members than smaller societies, often fewer than 20%, may need to be examined. Your Reference Committee recommends that Board of Trustees Report 46 be adopted.

(7) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

RECOMMENDATION:

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

This report examines physicians' ethical responsibility of commitment to competence and is concerned with a broader notion of competence -- one which deals with a physician's wisdom and judgment about their own ability to provide safe, high quality care. The report notes certain influences on clinical reasoning, such as heuristics, habits

of perception, and overconfidence, can lead to problems in effective reasoning. Hence, it is important to for physicians to develop an informed self-assessment that becomes self-awareness of a physician's own ability to practice safely in the moment and to develop a "mindful practice" over the course of their lifetime in order to ethically maintain competence. The report proposes guidance to this end.

Your Reference Committee heard testimony that was largely supportive of CEJA Report 1. Hesitations were raised regarding circumstances in which physicians do not possess the self-awareness to accurately assess their own competence, such as in the case of impairment, and such physicians should not be considered to be acting unethically. However, it was noted that the *Code of Medical Ethics* already offers guidance to physicians with impaired colleagues. While your Reference Committee is sensitive to the concerns raised during testimony, its judgment is that those concerns are adequately addressed by the report, and therefore recommends that Council on Ethical and Judicial Affairs Report 1 be adopted as written.

(8) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 2 - MERGERS OF SECULAR AND
RELIGIOUSLY AFFILIATED HEALTH CARE
INSTITUTIONS

RECOMMENDATION:

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

This report concerns mergers between religiously affiliated and secularly based health care institutions. CEJA intends the report to give ethical guidance about the challenges of such mergers. The report explains that mergers between religious and secular hospitals have been a factor in the U.S. since the 1990's, being driven often by economic considerations. CEJA explains that these mergers come with dilemmas. For example, Catholic institutions are bound to follow the Ethical and Religious Directives (ERDs), and the merger may risk the Catholic institution compromising the ERDs. Or, in the pursuit of adhering to the ERDs after merger, there may be conflicts with prevailing standards of care and limitations on certain practices, like some women's health services, that may be legal and clinically appropriate. CEJA explains that the Code of Medical Ethics is relevant where the Code discusses advocacy of patient needs, respect for patients, and exercise of a physician's conscience. CEJA recommends recognition of the benefits of mergers but also of the tensions they create and that individual physicians associated with merging institutions work to hold leaders accountable for professionalism within the institution and advocate for solutions when there are disagreements about services or arrangements for care.

Limited testimony was offered in unanimous support of CEJA Report 2 as a good step toward eliminating undue burdens on patients attempting to access certain health care services. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be adopted.

(9) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 3 - MEDICAL TOURISM

RECOMMENDATION:

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

This report responds to House Policy H-460.9896, "Stem Cell Tourism" adopted at the 2016 Annual meeting. This report provides guidance on the broader issue of medical tourism as a whole, rather than focusing specifically on stem cell tourism, stating that that medical tourism is a growing phenomenon. CEJA outlines the potential risks of medical tourism, and explains the associated ethical challenges including informed decision making, continuity of care, preservation of trust between physician and patient, and oversight.

Your Reference Committee heard no testimony opposing the adoption of CEJA Report 3, and therefore recommends adoption.

(10) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 4 - EXPANDED ACCESS TO
INVESTIGATIONAL THERAPIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 4 be adopted and that the remainder of the report be filed.

This report responds to D-460.967(2), "Study of the Current Uses and Ethical Implications of Expanded Access", which directs our AMA to study the ethics of expanded access programs and related issues. In response to the shortage of FDA approved therapies for certain life-threatening illnesses, the "expanded access" program was created to allow patients to access investigational therapies outside of a clinical trial. In 2009, the FDA created regulations to outline the parameters for how terminally ill patients can apply for expanded access. The report notes that applications for expanded access have grown steadily since its inception, with about 99.7% of the 11,000 applications between 2005 and 2014 being approved. CEJA further recognizes that there are ethical issues associated with expanded access, most notably that of informed consent. CEJA also discusses the financial and equity issues with the costs associated with expanded access, as well as public health ramifications, as expanded access may adversely affect successful completion of clinical trials. The report proposes guidance to physicians whose patients request expanded access to an investigational therapy.

Your Reference Committee heard testimony largely supportive of CEJA Report 4, as well as that the report is relevant in light of the newly-signed "Right to Try Act of 2017." Testimony noted that this report provides helpful guidance to physicians treating patients

with serious, life-threatening illnesses for whom standard therapies have not been effective. The concern was raised that the report places problematic responsibilities on front-line physicians rather than researchers, but alternate testimony pointed out that the recommendations in the report give physicians the right to decline support for patients seeking investigational therapies, and that responsibility does fall on the investigators. Your Reference Committee considered this concern, but agrees that the report does not place unfair responsibilities on the physician, and therefore recommends that CEJA Report 4 be adopted.

(11) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 5 - STUDY AID-IN-DYING AS END-OF-LIFE OPTION / THE NEED TO DISTINGUISH "PHYSICIAN ASSISTED SUICIDE" AND "AID IN DYING"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 5 be adopted and that the remainder of the report be filed.

CEJA Report 5 responds to Resolution 15-A-15, “Study Aid-in-Dying as End-of-Life Option,” and Resolution 14-A-17, “The Need to Distinguish between ‘Physician-Assisted Suicide’ and ‘Aid in Dying’.” Resolution 15-A-15 asks that CEJA study medical aid-in-dying and make a recommendation regarding the AMA taking a neutral stance; Resolution 14-A-17 asks that AMA define and clearly distinguish “physician assisted suicide” and “aid in dying” for use in all AMA policy and position statements. This report holds that these different terms of art reflect different ethical perspectives. The Council finds “physician assisted suicide” to be the most precise term and urges that it be used by AMA. The report notes that there are irreducible differences in moral perspectives regarding the issue of physician-assisted suicide, such that both sides share common commitment to “compassion and respect for human dignity and rights,” (see Principle I of the AMA Principles of Medical Ethics) but draw different moral conclusions from these shared commitments. The report considers the risks of unintended consequences of physician-assisted suicide, noting that there is debate about the available data. The report argues that where physician-assisted suicide is legal, safeguards can and should be improved in order to mitigate risk. The report further notes that too often physicians and patients do not have the conversations they should about death and dying and that physicians should be skillful in engaging in these difficult conversations and knowledgeable about the options available to terminally ill patients. CEJA Report 5 concludes that the *Code of Medical Ethics*, in its current form, offers guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life in the intimacy of the patient-physician relationship and in keeping with their deeply held personal beliefs. CEJA Report 5 recommends that the Code not be amended and that Resolutions 15-A-16 and 14-A-17 not be adopted.

Your Reference Committee heard extensive mixed, passionate testimony, including online, regarding CEJA Report 5. There was broad agreement that CEJA had written a strong report that thoroughly examines the issues under consideration, including

focusing on the shared values of care, compassion, respect, and dignity. Testimony offered a great deal of support, with a number of societies noting that CEJA's recommendations are in agreement with their own policies. Your Reference Committee also heard a significant amount of opposing testimony, including questions about whether the conclusions of the report were supported by its content. Ultimately, your Reference Committee agreed that the *Code of Medical Ethics* offers guidance to support physicians and the patients they serve in making decisions about legally available options for care at the end of life, and recommends that CEJA Report 5 be adopted.

(12) RESOLUTION 001 - DISCRIMINATORY POLICIES THAT CREATE INEQUITIES IN HEALTH CARE

RECOMMENDATION:

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

In response to the recently formed conscience and religious freedom division in the Department of Health and Human Services, created with intent to allow health professionals to opt out of providing services on grounds of religious liberty, the resolution asks that AMA speak against such policies that are discriminatory and perpetuate greater health disparities. The resolution further asks that our AMA be a voice for populations most vulnerable to such discriminatory policies.

Testimony for Resolution 001 expressed unanimous, strong support for the resolution, noting that our AMA has an obligation to identify disparities and advocate for and protect vulnerable populations. Your Reference Committee recommends that Resolution 001 be adopted.

(13) RESOLUTION 007 - OPPOSE THE CRIMINALIZATION OF SELF-INDUCED ABORTION

RECOMMENDATION:

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

Citing strong concerns of the many recent legal restrictions on abortion around the country, increases in women turning to self-induced abortions, and the increases in criminal prosecution of women for self-induced abortion, the resolution asks that our AMA oppose and advocate against the criminalization of self-induced abortion, as criminalization increases medical risks and deters women from seeking medically necessary services.

Your Reference Committee heard generally supportive testimony on Resolution 007. There was broad agreement that measures aimed at criminalizing self-induced abortion would increase risks to patients and discourage patients from seeking medical treatment. Limited opposing testimony was offered, and raised concerns about the potential timing of self-induced abortions. A proposed amendment recommended expanding the resolution to oppose efforts to criminalize abortion, including but not

limited to those that are self-induced, noting that our AMA currently does not have any policy in place addressing the legality of abortion. However, subsequent testimony did not support the amendment. Therefore, your Reference Committee recommends that Resolution 007 be adopted as written.

(14) RESOLUTION 016 - UTILIZATION OF "LGBTQ" IN RELEVANT PAST AND FUTURE AMA POLICIES

RECOMMENDATION:

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

Recognizing that the term “queer” is an umbrella term that encompasses anyone who does not associate with typical classifications of gender and sexual orientation, and that because of its expansiveness and inclusivity, more organizations and advocacy groups use “LGBTQ” instead of “LGBT”, the resolution calls for our AMA to utilize “LGBTQ” terminology in all future policies and to revise all relevant and active policies to incorporate “LGBTQ” terminology in replacement of “LGBT”.

No testimony was offered in opposition to Resolution 016, and your Reference Committee recommends that the resolution be adopted.

(15) RESOLUTION 002 - FMLA EQUIVALENT FOR LGBT WORKERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 002 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 002 be changed:

FMLA EQUIVALENCE

In response to the need and benefit for family and medical leave policies to be inclusive of LGBT workers, the resolution asks that our AMA advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

Testimony was generally supportive of the resolution, but there were several concerns about the language of “affinity” when describing relationships and whether or not this term was too vague or limiting. In an effort to better define “affinity”, a suggestion was made to modify the language to be “equivalent to first degree” of familial relationships. Your Reference Committee considered this suggestion and the concern with the term “affinity”, determining that the language is sufficient as written and that “affinity” is a term with appropriate legal definition. However, Your Reference Committee notes that the

title of Resolution 002 should be amended, in an effort to reflect its broader nature, to read as "FMLA Equivalence". Your Reference Committee recommends adoption with change in title.

(16) RESOLUTION 003 - PROPOSING CONSENT FOR DE-IDENTIFIED PATIENT INFORMATION

RECOMMENDATION A:

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

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 003 be changed:

RESEARCH HANDLING OF DE-IDENTIFIED PATIENT INFORMATION

Citing concerns that patients' de-identified personal health information is being harmfully used for commercial gain and other purposes, the resolution asks that our AMA study the handling of de-identified patient information and report its findings and recommendation back to the House of Delegates.

Testimony regarding the resolution was supportive, highlighting the need for further study on this issue. However, your Reference Committee noted that using the term "consent" in the title is misleading, as the resolve has no language regarding consent. Therefore, your Reference Committee recommends adoption with change in title to read: Research Handling of De-Identified Patient Information.

(17) BOARD OF TRUSTEES REPORT 25 - RECOGNITION OF PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT FORMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 25 be amended by addition and deletion to read as follows:

1. That our American Medical Association work with state medical associations to advocate with appropriate legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment (POLST) forms completed in one state as a valid ~~and enforceable in other states~~ expression of a patient's directions for care (Directive to take action).

2. That our AMA draft model state legislation and guidelines that will allow for reciprocity and/or recognition of POLST and other patient decision-making forms. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 25 be adopted as amended, and the remainder of the report be filed.

This report responds to Resolution 20-A-17, "Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms", which asked our AMA to advocate with government bodies to recognize POLST forms completed in one state as valid and enforceable in other states and for our AMA to create a universal POLST form that would be valid and enforceable in all states. POLST forms, first created in the 1990's to overcome the limitations of advance directives, have become a successful and useful end-of-life decision-making tool. However, POLST forms are not always recognized when patients cross state lines, potentially compromising patients' autonomy during end-of-life care. The report states that our AMA has numerous ethics policies, house policies, and directives that support the concept of advance care and end-of-life planning and notes that a possible solution to the problem has been raised by the National POLST Paradigm Task Force which recommends states adopt a "uniform law" that would offer reciprocity of POLST across state lines.

Testimony generally supported the intent of Board of Trustees Report 25, noting that advance care planning is crucial to ensuring that patients' wishes are respected and that patients do not receive unwanted care. However, your Reference Committee also heard testimony that discussed the complexity involved in physicians' orders being enforced in states where the ordering physician is not licensed. Several amendments were proposed that attempted to address this issue. Included in these amendments were suggestions that the Physician Orders for Life Sustaining Treatment (POLST) forms be recognized as a valid expression of a patient's directions for care, rather than explicitly stating that they be enforceable orders across state lines. Additionally, amendments were offered suggesting that AMA model state legislation and guidelines include not only POLST forms, but also other patient decision-making forms. Therefore, your Reference Committee recommends that Board of Trustees Report 25 be adopted as amended.

(18) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 - CCB SUNSET REVIEW OF 2008 HOUSE POLICIES

RECOMMENDATION A:

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

The Council on Constitution and Bylaws recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of Policy H-405.991, which should be retained and reconciled with H-405.996 to read as follows:

"~~Our AMA does not believe it would be appropriate to establish a separate committee to serve as a clearinghouse for service opportunities and to promote voluntary service, but~~ Our AMA supports continued promotion of community service and volunteerism by its membership and encourages state association awards for exceptional voluntary community service and wider recognition of physicians who perform voluntary services."

RECOMMENDATION B:

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

This report concerns the sunsetting of House Policies pursuant to Policy G-600.110, "Sunset Mechanism for AMA Policy". Under this mechanism, a policy ceases to be viable after 10 years unless the House takes action to retain it. The report notes, that the Council on Constitution and Bylaws presents its recommendations on the dispositions on House policies from 2008 to which it was assigned. The report recommends that the House policies listed in the Appendix be acted upon as indicated in the Appendix.

No opposing testimony was offered to CC&B Report 01. However, your Reference Committee has suggested an amendment to be integrated during the policy reconciliation for brevity. Thus, your Reference Committee recommends the adoption of CC&B Report 1 as amended.

(19) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 6 - CEJA'S SUNSET REVIEW OF 2008 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee, with the concurrence of the Council on Ethical and Judicial Affairs, recommends that the recommendation in CEJA Report 6 be amended by addition to read as follows:

House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of Policy H-25.997, which should be amended by deletion to read as follows:

The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs. ~~But the AMA does not believe that tax dollars of the working people of America should be used to finance medical care for any person who is financially able to pay for it.~~ Furthermore, the AMA believes in preserving dignity and self respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest. (Modify existing HOD policy)

RECOMMENDATION B:

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

This report addresses the sunsetting of House policies pursuant to G-600.110, “Sunset Mechanism for AMA Policy”, which mandates that House policies cease to be viable after 10 years unless action is taken to retain it. The report notes that for each policy it reviews, a Council may recommend one of the following actions: retain the policy, sunset the policy, retain part of the policy, or reconcile the policy with a more recent and like policy. In conclusion, the report recommends to the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated in the Appendix.

Your Reference Committee heard limited but unanimous testimony recommending that Policy H-25.997 be retained. Therefore, your Reference Committee recommends that Policy H-25.997 be amended to remain consistent with Policies H-165.838, H-165.888, and H-165.920. No further testimony was offered in opposition to CEJA Report 6, and your Reference Committee therefore recommends that the report be adopted as amended.

(20) RESOLUTION 004 - PATIENT-REPORTED OUTCOMES IN GENDER CONFIRMATION SURGERY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve in Resolution 004 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support initiatives and research developed by specialty societies and other relevant stakeholders to establish standardized protocols for patient selection, surgical management, and preoperative and postoperative care for transgender patients undergoing gender confirmation surgeries (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve in Resolution 004 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~development and~~ implementation of standardized tools, such as questionnaires, developed by specialty societies and other relevant stakeholders to evaluate outcomes of gender confirmation surgeries. (New HOD Policy)

RECOMMENDATION C:

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

Responding to the recent increase in gender confirmation surgeries and the current lack of a clear standard for patient election and education about certain procedures, the resolution asks that our AMA support research to establish standardized protocols for patient selection and care of transgender patients undergoing gender confirmation

surgeries. The resolution further asks that our AMA support the development and implementation of standardized tools, such as questionnaires, to evaluate surgical outcomes.

Testimony for Resolution 004 was unanimously supportive. Testimony suggested one amendment to insert language that our AMA initiatives and research be "developed from specialty societies". The rationale for this amendment is that there exist some reasonable basis that backs the initiatives and research that the resolve calls for. Your Reference Committee notes this testimony and supports amendment and agrees and recommends adoption with amendment.

(21) RESOLUTION 005 - DECREASING SEX AND GENDER DISPARITIES IN HEALTH OUTCOMES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 005 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association encourage the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes (New HOD Policy)~~

RESOLVED, That our AMA support the use of ~~gender-neutral~~ decision support tools that aim to mitigate gender bias in diagnosis and treatment; (New HOD Policy) and be it further

RESOLVED, That our American Medical Association encourage the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 005 be adopted as amended.

In response to recognized widespread sex and gender disparities in health care outcomes, the resolution ask that our AMA encourage the use of guidelines, tools and protocols specific to biological sex for conditions for which there are physiologic and pathophysiologic differences between the sexes and that our AMA support the use of gender-neutral tools to help mitigate gender bias in diagnosis and treatment.

Limited testimony heard by your Reference Committee unanimously supported the adoption of Resolution 005. Your Reference Committee believed that the intent of the resolution would be more effectively represented by reordering the two resolve clauses. Therefore, your Reference Committee recommends that Resolution 005 be adopted as amended.

(22) RESOLUTION 006 - LIVING DONOR PROTECTION ACT OF 2017 (HR 1270)

RESOLUTION 012 - COSTS TO KIDNEY DONORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends Policy H-370.965 be amended by addition and deletion:

1. Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (a) provisions for expenses involved in the donation incurred by the organ donor; (b) providing access to health care coverage of any medical expense related to the donation and; (c) provisions for expenses incurred after the donation as a consequence of donation; ~~(c)~~ (d) prohibiting employment discrimination on the basis of living donor status; ~~(d)~~ (e) prohibiting the use of living donor status as the sole basis for denying or limiting health, ~~and~~ life, and disability and long-term care insurance coverage; and ~~(e)~~ (f) provisions to encourage paid leave for organ donation.

2. Our AMA supports legislation expanding paid leave for organ donation.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Policy H-370.965 be adopted as amended in lieu of Resolutions 006 and 012.

RECOMMENDATION C:

Madam Speaker, your reference committee recommends that Policy H-370.996 be reaffirmed.

Resolution 006 is in response to the many burdens living organ donors face, such as difficulty obtaining life insurance or paying higher insurance premiums, the resolution

asks that our AMA strongly support the Living Donor Protection Act of 2017 (HR 1270). The Living Donor Protection Act addresses and attempts to ease burdens living donors have with insurance. Resolution 012 is in response to the significant expenses that living kidney donors incur both before and after donation and the disincentive to donation that these expenses create, the resolution asks that our AMA seek legislation to ensure that living kidney donors are reimbursed for expenses associated with donation of their kidney.

Testimony was largely supportive of the intentions of Resolution 006 and Resolution 012, both of which dealt with protections of organ donors and removing barriers to organ donation. A number of suggestions were made that the resolutions be addressed together, as they dealt with similar issues. Your Reference Committee also heard testimony that suggested that our AMA not adopt policy that references specific pieces of government legislation, as such bills are subject change. With regards to Resolution 006, a number of speakers suggested that the resolution be expanded to address all forms of organ donation rather than being limited specifically to kidney donors. Additionally, testimony on both items referenced currently existing AMA policy that addresses many of the issues that Resolutions 006 and 012 aim to address. Therefore, your Reference Committee recommends that current Policy H-370.965 be amended, and Policy H-370.996 be reaffirmed in lieu of Resolutions 006 and 012.

(23) RESOLUTION 008 - HEALTH CARE RIGHTS OF PREGNANT MINORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve in Resolution 008 be amended by addition to read as follows:

RESOLVED, That our AMA oppose any law or policy that prohibits a pregnant minor from ~~to~~ consenting to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, pain management, Cesarean section, diagnostic imaging, procedures, and emergency care. (Directive to Take Action)

RECOMMENDATION B:

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

In response to a number of states requiring parental consent of pregnant minors to receive prenatal care, such as genetic testing, epidural block, and cesarean section, the resolution asks that our AMA support legislation to allow pregnant minors to consent to all prenatal and postpartum care and procedures. The resolution further asks that our

AMA oppose any law that prohibits a pregnant minor from consenting to any pregnancy related care.

Testimony for Resolution 008 was unanimously supportive and offered amendments to expand the scope of procedures covered to include diagnostic imaging and procedures. However, considering the resolution, your Reference Committee suggests an amendment to language to further delineate "pregnancy related care". Your Reference Committee suggests amending the resolution to reflect forms of pain management beyond that of an epidural block. Additionally, the Reference Committee would like to add "diagnostic imaging, procedures, and emergency care" to the list of pregnancy related care, in an effort to give more complete examples of care in this regard. Your Reference Committee recommends that Resolution 008 be adopted as amended.

(24) RESOLUTION 014 - PROMOTION OF LGBTQ-FRIENDLY AND GENDER-NEUTRAL INTAKE FORMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 014 be amended by addition to read as follows:

RESOLVED, That our American Medical Association will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 014 be adopted as amended.

Considering evidence that only a very small percentage of intake forms are gender inclusive (able to identify transgender patients and not limited to binary gender), and that various LGBTQ groups have noted that including gender-neutral intake forms would improve the care of LGBTQ patients, and that our AMA is already has an established stance to the ongoing improvement of nonjudmental, nondiscriminatory, and culturally competent care of LGBTQ patients, the resolution calls for our AMA to distribute and promote to its members, the adoption of the recommendations pertaining to medical documentation and related forms in House Policy H-315.967 "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation."

Testimony in support of the resolution was unanimously supportive. There was a suggestion to leave the resolution substantively unchanged, but with an amendment to add language referencing that our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ issues and appropriate medical and community based organizations. The rationale for the amendment is to keep the resolution in accordance with the language of other similarly related house policies. Your Reference Committee noted the supportive testimony and request for amendment and is in agreement. Your Reference Committee recommends adoption with amendment.

(25) RESOLUTION 015 - HUMAN TRAFFICKING/SLAVERY AWARENESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 015 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery. ~~to ensure that physicians are trained to report suspected cases of human trafficking/slavery to the appropriate authorities while assuring victims have the medical, legal, and social resources they need and develop a plan of action to improve recognition of victims of human trafficking/slavery to increase the identification, referral, and rescue rate.~~ (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 015 be adopted as amended.

In response to the growing societal problem of human trafficking worldwide and the potential of physicians to act as first responders to this crisis, the resolution calls for our AMA to study the effectiveness of physician education to ensure that physicians are trained to report suspected cases of human trafficking/slavery to authorities and to develop a plan to improve recognition of victims to increase the rate of rescue.

Testimony for Resolution 015 was largely supportive, but there was concern about the language of “assuring victims have the medical, legal, and social resources they need”. However, your Reference Committee recognizes that awareness of educational resources should be a necessary element of the study. Therefore, your Reference

Committee suggests an amendment that the study also includes “awareness” as well as the effectiveness of physician education into these matters of human trafficking. Your Reference Committee recommends adoption as amended.

(26) RESOLUTION 018 - DISCRIMINATION AGAINST PHYSICIANS BY PATIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 018 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study (1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients’ requests ~~and expectations~~; (2) ~~how~~ hospitals’ and other health care systems’ ~~accommodate such patient requests, including but not limited to formal~~ policies or procedures ~~on~~ for handling patient bias; and (3) the legal, ethical, and practical implications of ~~that physicians and health care systems must consider when~~ accommodating or refusing such reassignment requests. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 018 be adopted as amended.

In response to patients who request accommodation based on race, gender, cultural or other biases, and a lack of guidance for hospitals and physicians for how to balance interests with regards to such accommodations, Resolution 018 calls for our AMA to study: (1) the prevalence, reasons for, and impact of physician reassignment based upon patients’ requests and expectations, (2) how hospitals and other health care systems accommodate such patient requests, including but not limited to formal policies or procedures on handling patient bias, and (3) the legal, ethical and practical implications that physicians and health care systems must consider when accommodating or refusing such reassignment request.

Testimony for Resolution 018 was unanimously supportive. There was a suggested amendment to add the language “physicians in training” to broaden the scope. Testimony noted that these issues are equally relevant for medical students and residents as well as practicing physicians. Your Reference Committee took note of this

testimony and recommendation and is in agreement and recommends adoption with amendment.

(27) RESOLUTION 019 - STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 019 by amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association determine the most efficient and accurate mechanism to study ~~conduct a study to accurately quantify~~ the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 019 be adopted as amended.

In response to our AMA addressing the core issue of suicide by physicians and physicians-in-training in 2010 and the resultant studies that help our AMA create policies, and in light of the growing problem of physicians and physicians-in-training facing burnout, depression, and suicide and the resultant need for an updated study to address these concerns for doctors before they enter medical school and beyond, Resolution 019 calls for our AMA to conduct a study to accurately quantify the actual incidence of medical student, resident and physician suicide, and report back with recommendations for action.

Testimony for the resolution was unanimously supportive. In considering the resolution, your Reference Committee notes the severity of the issue of physician suicide and the significant need for attention to this problem. However, our AMA does not generally conduct independent empirical research, and thus the Reference Committee suggests amending Resolution 019 so that the Board can determine the “most efficient and accurate mechanism to accurately quantify” (instead of a “study to accurately quantify”) the actual incidence of medical student, resident, and physician suicide. Your Reference Committee recommends adoption with amendment and a directive to report back findings at the 2018 Interim Meeting of the House of Delegates.

(28) RESOLUTION 010 - GENDER EQUITY IN COMPENSATION AND PROFESSIONAL ADVANCEMENT

RESOLUTION 011 - WOMEN PHYSICIAN WORKFORCE AND GENDER GAP IN EARNINGS-MEASURES TO IMPROVE EQUALITY

RESOLUTION 020 – ADVANCING THE GOAL OF EQUAL PAY FOR WOMEN IN MEDICINE

RESOLUTION 021 – TAKING STEPS TO ADVANCE GENDER EQUITY IN MEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 010, 011, 020 and 021.

ADVANCING GENDER EQUITY IN MEDICINE

RESOLVED, That our American Medical Association draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement (New HOD Policy); and be it further

RESOLVED, That our American Medical Association (AMA) recommend as immediate actions to reduce gender bias (a)

elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits (Directive to Take Action); and be it further

RESOLVED, That our AMA collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity (Directive to Take Action); and be it further

RESOLVED, That our AMA commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work. (Directive to Take Action)

Resolution 010 cites recent data showing significant differences in salary between male and female physicians (females physicians earning less than males) and the persistence of implicit bias that disadvantages women in male dominated professions, the resolution asks that our AMA advocate for: institutional policies regarding salary that promote transparency, equal base pay based on objective criteria, and implicit bias training. The resolution further asks that our AMA encourage a specified approach to compensation models that identify gender disparity and to establish education programs to help all genders negotiate equitable compensation.

Resolution 011 explains the continuing existence of the historical payment disparity gap between male and female physicians and the recent measures being taken to solve compensation disparity between the genders (such as the Lilly Ledbetter Fair Pay Act and the city of Chicago's mandate that employers cannot ask about salary history), the resolution asks that our AMA create an awareness campaign to inform physicians of

their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act. The resolution further calls on our AMA to help U.S. medical schools and facilities create guidance for institutional transparency of compensation and that our AMA recommend elimination any question of prior salary information from any physician job applications.

Resolution 020 responds to recent studies that demonstrate pay disparities for women physicians that being early in their careers and that gaps in compensation between men and women physicians widen over the career trajectory and that 48 states currently have some form of equal pay legislation, Resolution 020 calls for our AMA to draft and disseminate a report clarifying principles of equal pay in medicine that can form the basis for state and specialty society policy-making, as well as for academic medical centers and other physician employers, to be submitted to the House for consideration at the 2019 Annual Meeting.

Finally, Resolution 021 responds to women physicians having documented wage gaps in compensation and career advancement and published literature documenting that progress for women physicians has been slower than anticipated and national medical societies working to find solutions and publishing reports on this issue, Resolution 021 calls for our AMA to draft a report detailing its positions and recommendations for gender equity in medicine to be submitted to the House for consideration at the 2019 Annual meeting and that our AMA work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine with development of a report on the workshop findings.

Testimony for Resolutions 010, 011, 020 and 021 are all resolutions regarding gender equity and disparity in the medical profession, was largely supportive. There was strong support and recognition of a problem in of gender disparities in medicine and a need for further study on these problems. Testimony reflected the need for our AMA to set an example on this issue, by committing to pay equity for its employees. Considering that all four Resolutions are related to the same issue, the Reference Committee has decided to make one single resolution incorporating the recommendations of these four Resolutions. The new resolution includes new House policy, specific directives to reduce gender bias, and a call for a future study to continue exploring this important issue. Therefore, your Reference Committee recommends that the substitute resolution be adopted in lieu of Resolutions 010, 021, 011 and 020.

(29) RESOLUTION 013 - OPPOSING SURGICAL SEX ASSIGNMENT OF INFANTS WITH DIFFERENCES OF SEX DEVELOPMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 013 be referred.

Citing concerns that sex assignment surgery of infants with Differences of Sex Development (DSD) may be harmful, as such surgeries are permanent alterations before the patient is able to consent and may result in the infant patient being assigned a gender incongruent with their gender identity. The resolution calls for our AMA to oppose the assignment of gender binary sex to infants with DSD through surgical intervention

(except for surgery necessary for physical function) and believe that children should have meaningful input into any gender assignment surgery.

The testimony surrounding Resolution 013 was passionate and mixed. Supporting testimony argued that surgical sex assignment on infants was irreversible and sometimes conducted unnecessarily. Opposing testimony was offered suggesting that blanket bans on procedures inhibited physicians from providing care to their patients, and that surgery is never an automatic recommendation for infants with differences in sex development. The authors of the resolution recommended that Resolution 013 be referred, as this issue is currently under study by the Council on Ethical and Judicial Affairs Your Reference Committee ultimately agreed with authors that further study on the issue is necessary, and recommends that Resolution 013 be referred in anticipation of CEJA's report.

(30) RESOLUTION 017 - REVISED MISSION STATEMENT OF THE AMA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 017 not be adopted.

Considering that our AMA has been spending an increasing amount of time discussing physician burnout and malaise, the resolution asks that our AMA update its mission statement to read: The AMA promotes professionalism, the art and science of medicine, physician wellness and the betterment of public health.

Your Reference Committee heard testimony generally opposed to Resolution 017. It was noted by several speakers that the current mission statement of our AMA concisely conveys an appropriate message, and that a change is not necessary. Additionally, others expressed hesitation about attempting to wordsmith a new mission statement on the floor of the House. Your Reference Committee recommends that Resolution 017 not be adopted.

Madam Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Thomas Anderson, Jr., MD, Douglas Myers, MD, Mark Adams, MD, Robert Panton, MD, Brandi Ring, MD, and all those who testified before the Committee.

Thomas Anderson, Jr., MD
Illinois

Robert Panton, MD (Alternate)
Illinois

Douglas Myers, MD
Washington

Brandi Ring, MD (Alternate)
Colorado

Mark Adams, MD (Alternate)
New York

Peter H. Rheinstein, MD, JD, MS
Maryland
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee A

Jonathan D. Leffert, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 40 - Medicare Coverage of Services Provided by Proctored Medical Students
2. Council on Medical Service Report 2 - Improving Affordability in the Health Insurance Exchanges
3. Resolution 102 - Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children
4. Resolution 115 - Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

5. Council on Medical Service Report 1 - Council on Medical Service Sunset Review of 2008 AMA House Policies
6. Council on Medical Service Report 3 - Ensuring Marketplace Competition and Health Plan Choice
7. Council on Medical Service Report 7 - Insulin Affordability
8. Joint Report of the Council on Medical Service and the Council on Science and Public Health - Coverage for Colorectal Cancer Screening
9. Resolution 103 - Oppose Medicaid Eligibility Lockout
10. Resolution 104 - Emergency Out of Network Services
11. Resolution 111 - Medicare Coverage for Dental Services
12. Resolution 114 - Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI
13. Resolution 116 - Ban on Medicare Advantage "No Cause" Network Terminations

RECOMMENDED FOR REFERRAL

14. Resolution 108 - Expanding AMA’s Position on Healthcare Reform Options
15. Resolution 117 - Supporting Reclassification of Complex Rehabilitation Technology

RECOMMENDED FOR NOT ADOPTION

16. Resolution 109 - Medicaid Coverage of Fitness Facility Memberships

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

17. Resolution 105 - Use of High Molecular Weight Hyaluronic Acid
18. Resolution 118 - Payment for Advance Care Planning

19. Resolution 119 - Payment for Palliative Care

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 101 - Medicaid Reform
- Resolution 106 - Prohibit Retrospective ER Coverage Denial
- Resolution 107 - Opposition to Medicaid Work Requirement
- Resolution 110 - Return to Prudent Layperson Standard for Emergency Services
- Resolution 112 - Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
- Resolution 113 - Survivorship Care Plans

(1) BOARD OF TRUSTEES REPORT 40 - MEDICARE COVERAGE OF SERVICES PROVIDED BY PROCTORED MEDICAL STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 40 be adopted and the remainder of the report be filed.

Board of Trustees Report 40 recommends that our AMA not adopt Resolution 812-I-17.

Your Reference Committee heard mixed testimony on Board of Trustees Report 40. The Council on Medical Education and the Section on Medical Schools voiced their support for the report. Testimony calling for referral spoke to improving medical student education by ensuring student involvement in procedures. Compelling testimony provided by a contractor medical director in support of Board of Trustees Report 40 stated that teaching physicians can involve students and bill for their services that are personally supervised. The Board of Trustees testified that the Centers for Medicare & Medicaid Services has clarified that teaching physicians can involve students in services they perform, and to the extent that the medical student is involved in procedures under the personal supervision of a teaching physician who is performing the service, there is no prohibition against the teaching physician billing for these services. Any contribution and participation of a student in the performance of a billable service must be performed in the physical presence of a teaching physician or resident in service that meets teaching physician billing requirements. Accordingly, your Reference Committee recommends that the recommendation of Board of Trustees Report 40 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 2 - IMPROVING AFFORDABILITY IN THE HEALTH INSURANCE EXCHANGES

RECOMMENDATION:

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

Council on Medical Service Report 2 recommends that our AMA support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level; support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; and support the establishment of a permanent federal reinsurance program.

There was generally supportive testimony on Council on Medical Service Report 2. In introducing the report, a member of the Council on Medical Service underscored that the recommendations of the report aim to continue the coverage gains made since the enactment of the Affordable Care Act, while taking steps to further stabilize premiums in health insurance exchanges. Testimony raised concerns that the report did not address the important issues of high deductibles and other patient cost-sharing requirements. However, the Council on Medical Service responded that individuals with incomes up to 250 percent of the federal poverty level qualify for cost-sharing reductions to lower and limit their cost-sharing responsibilities if they enroll in a silver plan. In addition, the Council noted that premiums for the silver plans upon which premium tax credit amounts are based increased significantly from 2017 to 2018. Not only has this resulted in higher premium tax credit amounts for individuals who are eligible for them, but in some counties, the premium of the lowest-cost gold plan is less than that of the lowest-cost silver plan. Importantly, gold plans have lower out-of-pocket costs than silver and bronze plans.

The Council on Medical Service also shared that it is presenting a report for the 2018 Interim Meeting addressing the first-dollar coverage of services. Your Reference Committee also notes that there exists on the health insurance exchanges a trade-off between selecting plans with lower premiums that have higher out-of-pocket costs, and plans with higher premiums that have lower out-of-pocket costs. In addition, existing policy guides AMA advocacy efforts concerning patient cost-sharing requirements of exchange plans. Policy H-165.846 supports requiring provisions to be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. In addition, for low-income individuals who qualify for cost-sharing reductions who instead enroll in a bronze plan with higher out-of-pocket costs, Policy H-165.828 encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy. This change would help affected individuals meet the deductibles and other cost-sharing obligations of their bronze plan. Your Reference Committee believes that Council on Medical Service Report 2 is highly consistent with AMA advocacy efforts in support of ACA marketplace stabilization, taking steps toward coverage and access for all Americans, and ensuring low and moderate income patients are able to secure affordable and adequate coverage. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

(3) RESOLUTION 102 - EFFECTIVENESS OF RISK ASSESSMENT MODELS IN REPRESENTING HEALTHCARE RESOURCES EXPENDED FOR INFANTS AND CHILDREN

RECOMMENDATION:

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

Resolution 102 asks that our AMA support risk modeling that appropriately represents care that is specific to all age groups including infants, children, and adolescents as unique risk strata; and advocate that health insurance organizations transparently publish their risk adjustment models so that clinicians can more effectively document care that reflects patient risk and so that clinicians can assess whether the risk adjustment model appropriately defines the risk of their patients.

Testimony on Resolution 102 was unanimously supportive. Your Reference Committee believes that Resolution 102 is consistent with AMA policy addressing risk adjustment and recommends its adoption.

(4) RESOLUTION 115 - EXPANDING ON-SITE PHYSICIAN HOME HEALTH CARE TO LOW-INCOME FAMILIES AND THE CHRONICALLY ILL

RECOMMENDATION:

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

Resolution 115 asks that our AMA amend Policy H-210.981, "On-site Physician Home Health Care," by addition and deletion as follows: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can ~~only~~ be met by an increase in physician house calls to this vulnerable, underserved population; (5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or ~~excessively tiring and painful for~~ detrimental to the patient's health; (7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults; and (11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, ~~and~~ severity of illness, and socioeconomic status.

Testimony on Resolution 115 was unanimously supportive. Your Reference Committee believes that Resolution 115 is consistent with AMA policy addressing home health care and recommends its adoption.

(5) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2008 AMA HOUSE POLICIES

RECOMMENDATION A:

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

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of Policies D-335-984 and H-185.948, which should be retained. (Directive to Take Action)

RECOMMENDATION B:

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

Council on Medical Service Report 1 contains recommendations to retain or rescind 2008 AMA socioeconomic policies.

Your Reference Committee heard generally supportive testimony on Council on Medical Service Report 1. However, there were two suggested amendments to the report. First, an amendment was offered to retain Policy D-335-984 regarding Medicare Part B contractor changes. Another speaker testified that Policy H-185.948, regarding health insurance for children, should be retained as still relevant. Your Reference Committee agrees, and therefore recommends adoption of Council on Medical Service Report 1 as amended.

(6) COUNCIL ON MEDICAL SERVICE REPORT 3 - ENSURING MARKETPLACE COMPETITION AND HEALTH PLAN CHOICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

2. That our AMA oppose the sale of health insurance plans in the individual and small group markets that do not ~~comply with Affordable Care Act requirements, including those related to~~ guarantee: a) pre-existing condition protections and b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months.

RECOMMENDATION B:

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

Council on Medical Service Report 3 recommends that our AMA support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; oppose the sale of health insurance plans in the individual and small group markets that do not comply with Affordable Care Act requirements, including those related to pre-existing condition protections and essential health benefits, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation; reaffirm Policies H-165.838 and D-180.986; and rescind Policies H-165.882 and D-165.934.

Your Reference Committee heard mixed but predominantly supportive testimony on Council on Medical Service Report 3. In introducing the report, a member of the Council on Medical Service outlined an amendment to the second recommendation of the report to remove specific reference to the Affordable Care Act. Your Reference Committee accepts the amendment, noting that the amended wording of the recommendation still would achieve the intent of opposing the sale of health insurance plans in the individual and small group markets that do not guarantee critical patient protections and meet strong coverage standards. Importantly, the recommendation provides an exception for short-term limited duration insurance (STLDI) offered for no more than three months. Your Reference Committee underscores that the purpose of STLDI coverage is to serve as a bridge between coverage in plans offering meaningful coverage. As such, limiting the duration of its offering to three months is appropriate, especially as STLDI plans do not have to comply with the market reforms and consumer protections of the ACA. As such, STLDI plans can deny coverage or charge higher premiums based on health status; exclude coverage for pre-existing conditions; impose annual or lifetime limits; have higher out-of-pocket limits than the ACA maximums; not cover categories of essential health benefits; rescind coverage; and not comply with medical loss ratio requirements.

A speaker opposed the rescission of Policy H-165.882, stating that it was not aptly superseded by the policy cited in the report. However, your Reference Committee notes that Policy H-165.882 is in direct conflict with the first and second recommendations of Council on Medical Service Report 2. Policy H-165.882 supports certain plans being allowed to be exempt from selected state regulations regarding mandated benefits and small group rating laws to achieve lower premiums. In addition, the policy encourages certain entities including farm bureaus to be included as entities that would be exempt from such laws. Your Reference Committee notes that the Council report explicitly details the adverse impacts of laws that enable such farm bureau plans in states including Iowa and Tennessee. The remainder of the policy is superseded by AMA policy in support of value-based insurance design (Policies H-185.939 and H-155.960) and the multitude of AMA policies in support of covering the uninsured. In addition, your Reference Committee notes that the reference in Policy H-165.882 to Consumer Operated and Oriented Plans (CO-OPs) established by the ACA is outdated, as most

CO-OPs failed in the early years of operation. There was also testimony raising concerns with narrow networks, high deductibles and underinsurance, all of which are addressed in this report, CMS Report 2-A-18, and/or existing policy on health plan affordability and network adequacy. Your Reference Committee also notes that some issues raised in testimony were not germane to the topic of Council on Medical Service Report 3.

Your Reference Committee believes that this report is incredibly timely, as some regulations that have been proposed this year would allow exceptions to key protections that the ACA affords in the arenas of pre-existing condition protections, essential health benefits, annual and lifetime limits, out-of-pocket maximums, prohibitions on gender rating, medical loss ratio requirements, and rate review. In addition, the FEHBP recommendation of the report will ensure patients are not left without coverage options in the marketplaces, while enabling patient choice of private health plans, ensuring physician freedom of practice, not requiring physician participation, and recognizing the value of payment rates being established through meaningful negotiations and contracts. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 7 - INSULIN AFFORDABILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation 5 in Council on Medical Service Report 7 be amended by deletion to read as follows:

5. That our AMA support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies ~~and the appropriate use of regular human insulin and neutral protamine Hagerdorn (NPH)~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

Council on Medical Service Report 7 recommends that our AMA encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; disseminate model state legislation to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication; provide assistance upon request to

state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency; support physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale; support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies and the appropriate use of regular human insulin and neutral protamine Hagerdorn (NPH); and reaffirm Policies H-110.992, H-110.987, H-100.980, H-125.979, H-185.939, H-155.960, H-110.986 and H-110.990.

The preponderance of testimony was supportive of Council on Medical Service Report 7. A member of the Council on Medical Service introduced the report, noting that a variety of factors contribute to increases in insulin prices, and emphasized that the report sets forth potential options for improving insulin affordability. A member of the Council on Legislation testified that federal and state governments and patient advocates are currently engaged in actions in response to the trend of increasing insulin prices. The Council member also noted that the AMA recently developed model state legislation that encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs, and health insurance companies.

A speaker on behalf of the American Association of Clinical Endocrinologists expressed appreciation for the report and introduced a series of amendments, proposing that the AMA disseminate additional model state legislation, seek legislation or regulations that advance formulary transparency, and convene a summit to identify solutions to ease the financial burden on patients due to costs of insulin. The American Association of Clinical Endocrinologists also testified that newer insulin is superior to older insulin because of decreased incidence of hypoglycemia, which is particularly important for elderly patients. Similarly, a speaker on behalf of the Endocrine Society applauded the report, supported the amendments offered by the American Association of Clinical Endocrinologists, and emphasized the appropriate use of older insulin, as stated in the report. The Council on Medical Service testified that the goals sought in the proposed amendment that are consistent with AMA policy have already been achieved via previous and ongoing AMA activity. For example, testimony continued, the AMA developed model state legislation that requires that health plans offer the same formulary throughout the plan year, be transparent about what their formularies include when patients purchase plans, and not increase patient cost-sharing during a plan year if the health plan or PBM removes a medication from its formulary or moves the medication to a higher cost-sharing tier during a plan year. Several states have enacted and/or are considering similar legislation, and the AMA continues to urge state medical associations to have the AMA Model Act introduced. Other goals sought by the proposed amendment, while understandable, are not consistent with AMA policy. The Council of Medical Service explained that AMA policy favors consumer choice and broadly advocates for improved access to affordable prescription drugs without prioritizing any one prescription drug over others. The Council of Medical Service cautioned against convening a summit specifically on insulin affordability, as this could establish a precedent by which summits on countless other essential drugs could become necessary. Your Reference Committee agrees that a summit would not necessarily effect change since only the House of Delegates, not summit participants, can adopt AMA policy. Your Reference Committee notes that later this month, the AMA will be convening members of the Federation to coordinate a response to the White House's Blueprint to Lower Drug Prices.

Your Reference Committee believes that Council on Medical Service Report 7 builds upon our AMA's strong policy and advocacy foundation addressing drug pricing and contains strong recommendations to respond to insulin pricing specifically. In response to testimony regarding the use of older insulins, your Reference Committee recommends that Recommendation 5 be amended by deletion of reference to the appropriate use of regular human insulin and neutral protamine Hagerdorn. Your Reference Committee recommends that the recommendations of Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

(8) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - COVERAGE FOR COLORECTAL CANCER SCREENING.

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by deletion of Recommendation 4 as follows:

~~4. That our AMA reaffirm Policy H-390.849, which advocates for physician payment reform consistent with: promoting improved patient access to high-quality, cost-effective care, promoting designs that incorporate input from the physician community, and providing patients with information and incentives to encourage appropriate utilization of preventive services. (Reaffirm HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by deletion of Recommendation 5 as follows:

~~5. That our AMA reaffirm Policy H-425.992, which advocates for revision of current Medicare guidelines to include coverage of appropriate preventive services. (Reaffirm HOD Policy)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 7 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion to read as follows:

7. That our AMA ~~encourage the development of a coding guide to help providers appropriately bill for various colorectal cancer screening services and promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels.~~ seek to eliminate cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a "diagnostic" intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Recommendation 8 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion to read as follows:

8. That Policy H-55.981, "Carcinoma of the Colon and Rectum," be amended by addition and deletion to read as follows:

Our AMA supports: (1) Recognizing colon cancer as a leading cause of cancer deaths in the United States and encouraging appropriate screening programs to detect colorectal cancer. ~~Appropriate screening programs to detect colorectal cancer in individuals who are older than 50 years of age or have risk factors.~~ ~~(2) The general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which~~ screen ~~the entire colon, should be considered as appropriate alternatives. (3)~~ (2) Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more intensive screening efforts. ~~(4)~~ (3) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that ~~may become~~ are available in this area. (4) Physicians engaging their patients in shared decision-making, including consideration of both clinical and financial patient impacts, to determine at what age to begin

screening for colorectal cancer and which screening method (or sequence of methods) is most appropriate. (Modify Current HOD Policy)

RECOMMENDATION E:

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

That our AMA reaffirm Policy H-330.877, which states that our AMA supports requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure.

RECOMMENDATION F:

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

The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our reaffirm Policies D-330.935, D-330.967, H-185.960, H-390.849 and H-425.992; amend Policy H-55.981 by deletion to remove "(2) The general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which screen the entire colon, should be considered as appropriate alternatives."; continue to support Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements; and encourage the development of a coding guide to help providers appropriately bill for various colorectal cancer screening services and promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was supportive. A member of the Council on Medical Service introduced the report and offered several amendments to strengthen the recommendations in the report, including striking the fourth and fifth recommendations, observing that while very important, the policies recommended for reaffirmation are peripheral to the colorectal cancer screening issue. Second, the Council member recommended amending the seventh recommendation, noting that the coding guide will advance the goal of eliminating cost-sharing for the full range of colorectal cancer screening, including colonoscopies that include removal of a polyp or biopsy of a mass. Third, the Council member recommended amending the eighth recommendation to recognize that clinical practice guidelines for colorectal cancer screening will continue to evolve over time, as well as support physicians and patients engaging in joint decision-

making that considers both clinical and financial patient impacts, to determine at what age to begin screening for colorectal cancer and which screening method (or sequence of methods) is most appropriate. Finally, the Council member recommended adding a new recommendation which reaffirms Policy H-330.877, emphasizing that this policy continues to be highly relevant. A member of the Council on Science and Public Health testified in support of these amendments. Your Reference Committee accepts these amendments. A member of the American Society of Anesthesiologists testified that cost-sharing should be waived for all of the costs associated with a screening colonoscopy. Your Reference Committee accepts this amendment and included it in the seventh recommendation of the report.

An additional amendment was offered that called on the AMA to advocate for coverage of screening colonoscopies without cost-sharing, including when additional procedures (e.g. removal and biopsy of suspicious tissue) are required. Similarly, an amendment was offered which supported the "cascade of events" approach to screening outlined in the Joint Report. Your Reference Committee believes that the goals of both amendments are accomplished by the Joint Report, AMA policy, and the amendments offered by the member of the Council on Medical Service. Accordingly, your Reference Committee recommends adoption of the Joint Report as amended.

(9) RESOLUTION 103 - OPPOSE MEDICAID ELIGIBILITY LOCKOUT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 103 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our American Medical Association oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods ~~merely for failing to meet paperwork burdens or deadlines~~, and support provisions that permit them to reapply immediately for redetermination. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 103 be <u>adopted as amended</u>.

Resolution 103 asks that our AMA oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods merely for failing to meet paperwork burdens or deadlines, and support provisions that permit them to reapply immediately for redetermination.

Your Reference Committee heard highly supportive testimony on Resolution 103. An amendment was offered to clarify that our AMA oppose 'lock-out' provisions, irrespective of the reason for their application. Testimony noted that lock-out provisions could be triggered for more reasons than when paperwork burdens and deadlines are not met.

Rather, states have proposed that they be triggered for failure to comply with a multitude of administrative requirements. In states pursuing lock-outs, patients can be barred from Medicaid and lose important access to needed health care services for failing to meet deadlines, satisfy work requirements, or make premium payments on time – even if they subsequently comply with the requirements within the lock-out period. In many cases, lock-outs will punish patients who fail to keep up with paperwork but otherwise continue to meet the underlying eligibility criteria for coverage. Accordingly, your Reference Committee recommends that Resolution 103 be adopted as amended.

(10) RESOLUTION 104 - EMERGENCY OUT OF NETWORK SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 104 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association pursue legislation or regulation to require health plans not regulated by their states (such as ERISA plans) to pay physicians for emergency out of network care at least at the 80th percentile of charges for that particular geo-zip, as reported by the Fair Health database. (Directive to Take Action)~~

RESOLVED, That our American Medical Association advocate for health plans to cover out-of-network unanticipated or emergency care at a fair percentile of all charges for the particular health care service provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization unaffiliated with health insurance companies. (New HOD Policy)

RECOMMENDATION B:

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

Resolution 104 asks that our AMA pursue legislation or regulation to require health plans not regulated by their states (such as ERISA plans) to pay physicians for emergency out of network care at least at the 80th percentile of charges for that particular geo-zip, as reported by the Fair Health database.

There was mixed testimony on Resolution 104. Several speakers, including members of the Council on Medical Service and the Council on Legislation, testified in support of removing specific reference to FAIR Health and the 80th percentile of charges, with the Council on Legislation introducing an amendment to achieve said objective. Another amendment introduced removed reference to FAIR Health but kept reference to the 80th

percentile of charges, which some speakers stressed would undermine state laws and activities on this issue, as well as existing AMA policy.

The member of the Council on Legislation noted that our AMA already promotes the 80th percentile of charge data in our model state legislation on unanticipated out-of-network care. Importantly, the member of the Council on Legislation noted that requiring the use of FAIR Health in our policy could preclude the future use of other resources, including state all-payer claims databases, in the future. Your Reference Committee agrees, and believes our AMA should support legislation that uses such databases, as long as they are independent. Importantly, removing the explicit reference to FAIR Health and the 80th percentile of charges promotes the evergreen nature of our policy. Testimony also raised concerns that there could be legal concerns surrounding the intersection of ERISA plans and state laws. Your Reference Committee also believes that the amendment offered by the Council on Legislation would apply to all health plans, including ERISA plans, is consistent with existing Policy H-285.904, and does not raise legal concerns associated with ERISA. Accordingly, your Reference Committee recommends that Resolution 104 be adopted as amended.

(11) RESOLUTION 111 - MEDICARE COVERAGE FOR DENTAL SERVICES

RECOMMENDATION A:

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

~~RESOLVED, That our American Medical Association reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our healthcare team (New HOD Policy); and be it further~~

RESOLVED, That our American Medical Association ~~AMA promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients~~ explore opportunities to work with the American Dental Association to improve access to dental care for Medicare beneficiaries. (Directive to Take Action)

RECOMMENDATION B:

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

RECOMMENDATION C:

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

ACCESS TO DENTAL SERVICES FOR MEDICARE BENEFICIARIES

Resolution 111 asks that our AMA reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our healthcare team; and promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients.

Testimony on Resolution 111 was generally mixed. Multiple speakers commended the intentions motivating Resolution 111, but they expressed concern about whether our dental colleagues would share these goals, as proposed, and the strain that Resolution 111 could impose upon the Medicare program. Accordingly, these speakers recommended that Resolution 111 be referred for study. A member of the Council on Medical Service testified that the concerns raised in testimony could be addressed by amending Resolution 111 to state that the AMA will explore opportunities to collaborate with the American Dental Association in efforts to improve access to dental care for Medicare beneficiaries, and that this amendment is preferable to a referral. Your Reference Committee notes that the Council's amendment is consistent with AMA policy and strikes a successful balance in responding to both the commendable intentions of Resolution 111 and the concerns raised in testimony. Accordingly, your Reference Committee recommends that Resolution 111 be adopted as amended, with a change in title to reflect the amendment made to the resolution.

(12) RESOLUTION 114 - INCLUSION OF BUNDLED PAYMENTS CARE IMPROVEMENT (BPCI) POST-ACUTE ONLY MODEL 3 IN ADVANCED BPCI

RECOMMENDATION A:

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

~~RESOLVED, That our American Medical Association advocate for inclusion of the existing Bundled Payments Care Improvement (BPCI) Model 3 Post-Acute care bundle in the Advanced BPCI program so that physicians working in Skilled Nursing Facilities (SNFs) and SNFs are allowed to initiate episodes of care bundles. (New HOD Policy)~~

RESOLVED, That our American Medical Association work with interested national medical specialty societies to help develop and advocate for one or more Medicare

alternative payment models focusing on post-acute and/or long-term care. (New HOD Policy)

RECOMMENDATION B:

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

Resolution 114 asks that our AMA advocate for inclusion of the existing Bundled Payments Care Improvement (BPCI) Model 3 Post-Acute care bundle in the Advanced BPCI program so that physicians working in Skilled Nursing Facilities (SNFs) and SNFs are allowed to initiate episodes of care bundles.

Your Reference Committee heard limited testimony on Resolution 114. Testimony from the Council on Legislation explained that one of the key differences between BPCI "classic" and BPCI Advanced is that BPCI-A is prospectively priced, and the need to know ahead of time what a participant's spending target is is very important to the participants. The Council member noted that there is no way for CMMI to prospectively set a price for an episode that does not begin until the patient is in the post-acute care phase. That being said, CMMI continues to explore episode payment models for post-acute as well as other Medicare services, and is interested in a model in the post-acute space that could support the IMPACT Act of 2014 goal of payment reform for post-acute services. As such, COL offered the amended language with which the author agreed. Accordingly, your Reference Committee recommends that Resolution 114 be adopted as amended.

(13) RESOLUTION 116 - BAN ON MEDICARE ADVANTAGE "NO CAUSE" NETWORK TERMINATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 116:

RESOLVED, That our AMA develop a set of reform proposals addressing the way that Medicare Advantage plans develop and modify their physician networks with the aim of improving the stability of networks, the ability of patients to obtain needed primary and specialty care from in-network physicians, physician satisfaction, and communication with patients about network access (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm Policy D-285.988, which states that our AMA will seek legislation that would prohibit Medicare managed care companies from terminating without cause an enrollee's contracted physician before the enrollee's first subsequent open enrollment period (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-285.908, which supports requiring that provider terminations without cause be done prior to the enrollment period, and supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-285.991, which outlines that prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. (Reaffirm HOD Policy)

Resolution 116 asks that our AMA advocate for legislation that would ban Medicare Advantage plans from issuing "no cause" network terminations, require a Medicare Advantage plan that terminates a physician from a network to provide substantive reasons for such termination, require such termination to be sent by certified mail, require that the Medicare Advantage plan provide at least sixty (60) days for physicians to appeal such termination; and require that the Medicare Advantage plan provide the physician with a listing of the impacted patient names and a copy of the correspondence sent to impacted patients.

There was generally supportive testimony on the intent of Resolution 116. A member of the Council on Legislation noted that, as existing policy addresses the intent of Resolution 116, efforts should instead focus more on fixing the underlying problems that may have led to the introduction of the resolution. Accordingly, the Council member offered an amendment in support of our AMA developing a set of reform proposals addressing the way that Medicare Advantage plans develop and modify their physician networks. Your Reference Committee thanks the Council on Legislation for its amendment, and agrees with its direction, which will spur new AMA activity on this issue versus duplicating the intent of existing policy. Another amendment was offered that your Reference Committee found duplicative of existing policy. Your Reference Committee has crafted alternative language that includes the Council on Legislation amendment, and reaffirms critical policies that not only provide the criteria to follow for no-cause terminations, but explicitly state that our AMA will seek legislation that would prohibit Medicare managed care companies from terminating without cause an enrollee's contracted physician before the enrollee's first subsequent open enrollment period.

D-285.988 Managed Care Contract Deadline
1. Our AMA will draft model state legislation and amend the AMA's Model Managed Care Contract to reflect AMA policy regarding the marketing of physicians as network participants. 2. Our AMA will seek legislation that would prohibit Medicare managed care companies from terminating without cause an enrollee's contracted physician before the enrollee's first subsequent open enrollment period. (Sub. Res. 703, I-00; Reaffirmed: BOT Rep. 6, A-10; Appended: Res. 809, I-11)

H-285.908 Network Adequacy
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements. 2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. 3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. 4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies. 6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician. 8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. 9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. 10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited. 11. Our AMA advocates that health plans should be required to document to

regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible. 12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17)

H-285.991 Qualifications and Credentialing of Physicians Involved in Managed Care

1. AMA policy on selective contracting is as follows: (a) Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted. (b) Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have that application approved if it meets physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualifications, competence and quality of care. (c) Selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system. (d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. Participation in a physician health program in and of itself shall not count as a limit on the ability to practice medicine. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (i) the specific reasons for the termination or nonrenewal should be provided in sufficient detail to permit the physician to respond; (ii) a name and address of the Director of Provider Appeals, or an individual with equivalent authority, should be provided for the physician to direct communications; (iii) the evidence or documentation underlying the proposed termination or nonrenewal should be provided and the physician should be permitted to review it upon request; (iv) the physician should have the right to request a hearing to challenge the proposed termination or nonrenewal; (v) the physician or his/her representative should be able to appear in person at the hearing and present the physician's case; (vi) the physician should be able to submit supporting information both before and at the fair hearing; (vii) the physician should have a right to ask questions of any representative of the health insurance company who attends the hearing; (viii) the physician should have at least thirty days from the date the termination or nonrenewal notice was received

to request a hearing; and (ix) the hearing must be held not less than thirty days after the date the health insurer receives the physician's request for the review or hearing. 2. The qualifications, responsibilities, and duties of physicians employed as medical directors of managed care plans should be developed on an individual basis by the plan concerned. Physicians who participate in the plan, or the plan's medical staff, if one is so designated, should participate in developing such qualifications, responsibilities, and duties. (CMS Rep. B, A-93; BOT Rep. I-93-25; Reaffirmed: Sub. Res. 704, I-94; Reaffirmed: Sub. Res. 701, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed by Res. 108, A-98; Reaffirmation A-01; Appended: CMS Rep. 8, A-10; Reaffirmed: Res 119, A-14; Modified: Res. 708, A-14; Reaffirmation A-14; Reaffirmed: CMS Rep. 4, I-14)

(14) RESOLUTION 108 - EXPANDING AMA'S POSITION ON HEALTHCARE REFORM OPTIONS

RECOMMENDATION:

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

Resolution 108 asks that our AMA rescind Policies H-165.844 and H-165.985; amend Policy H-165.888 by deletion to remove "1(B) Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be oppose;" and amend Policy H-165.838 by deletion to remove "12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform."

Your Reference Committee heard mixed testimony on Resolution 108. A member of the Council on Medical Service recommended reaffirmation of existing policy in lieu of Resolution 108, and shared the Council’s belief that the current approach of our AMA’s policy to health reform is the right one – emphasizing pluralism, freedom of choice, freedom of practice and universal access to patients. Another Council member noted that the Council has already studied international approaches to single payer. Testimony on both sides was passionate. Testimony in opposition raised concerns that Resolution 108 would open the door to the AMA supporting single payer, while testimony in support of the resolution noted the changes to policy outlined in the resolution would enable the AMA to participate in legislative discussions addressing single payer. An amendment was also offered to call for a study. Your Reference Committee underscores that this issue is highly complicated, and there is a need to examine AMA policy addressing health reform and single payer, study the pros and cons of single payer and alternative approaches to universal coverage, and study the impacts of single payer systems on physician practices and patients. As such, your Reference Committee recommends that Resolution 108 be referred.

(15) RESOLUTION 117 - SUPPORTING RECLASSIFICATION OF COMPLEX REHABILITATION TECHNOLOGY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 117 be referred.

Resolution 117 asks that our AMA advocate for the Centers for Medicare & Medicaid Services to reclassify complex rehabilitation technology as a separate and distinct payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs.

Your Reference Committee heard supportive testimony on Resolution 117, but a member of the Council on Medical Service cautioned that it would be premature to adopt Resolution 117 without further study. In calling for referral, the Council member testified that Resolution 117 may have unintended impacts and consequences. Your Reference Committee commends the Council of Medical Service's testimony and recommends that Resolution 117 be referred.

(16) RESOLUTION 109 - MEDICAID COVERAGE OF FITNESS FACILITY MEMBERSHIPS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 109 not be adopted.

Resolution 109 asks that our AMA support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for patients.

While testimony was mixed, the preponderance of the testimony was opposed to Resolution 109. Several speakers testified regarding the significant limitations on funding for the Medicaid program and expressed concerns that Resolution 109 would impose further strain on the Medicaid program. Additional testimony emphasized that there is insufficient evidence to support the efficacy of fitness facility membership as a preventive health benefit. A member of the Council on Medical Service offered an amendment to remove the resolution's specific reference to "fitness facility memberships," and generalize the language to support Medicaid coverage of prevention and wellness initiatives. Your Reference Committee agrees with the significant testimony expressing concern that Resolution 109 could further strain the resources of the Medicaid program and notes that AMA policy generally avoids mandating coverage of specific benefits, both to better allow markets to determine benefit packages and to avoid jeopardizing current coverage. Accordingly, consistent with AMA policy and the weight of the testimony, your Reference Committee recommends that Resolution 109 not be adopted.

(17) RESOLUTION 105 - USE OF HIGH MOLECULAR WEIGHT HYALURONIC ACID

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-165.856, H-185.964, H-385.942, H-410.961 and H-450.935 be reaffirmed in lieu of Resolution 105.

Resolution 105 asks that our AMA advocate for reimbursement and national coverage for high molecular weight hyaluronic acid intraarticular injections as appropriate care and treatment for patients with mild to moderate osteoarthritis of the knee.

Your Reference Committee heard mixed testimony on Resolution 105. A member of the Council on Medical Service testified that AMA policy on clinical practice guidelines raises concerns with such guidelines being used inappropriately as the basis for payment decisions, and that AMA policy generally avoids mandating coverage of specific benefits, both to better allow markets to determine benefit packages and to avoid jeopardizing current coverage. Accordingly, the member of the Council on Medical Service called for reaffirmation of Policies H-165.856 and H-185.964 addressing benefit mandates, and H-385.942, H-410.961 and H-450.935 addressing the use of clinical practice guidelines. Your Reference Committee agreed with the Council's recommendation. As such, your Reference Committee recommends that Policies H-165.856, H-185.964, H-410.961, H-410.997 and H-450.935 be reaffirmed in lieu of Resolution 105.

H-165.856 Health Insurance Market Regulation
Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan. (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection. (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges. (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium. (5) Insured individuals should be protected by guaranteed renewability. (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices. (7) Guaranteed issue regulations should be rescinded. (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage. (10) The regulatory environment should enable rather than impede private market innovation in product

development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03 Reaffirmed: CMS Rep. 6, A-05 Reaffirmation A-07 Reaffirmed: CMS Rep. 2, I-07 Reaffirmed: BOT Rep. 7, A-09 Appended: Res. 129, A-09 Reaffirmed: CMS Rep. 9, A-11 Reaffirmed in lieu of Res. 811, I-11 Reaffirmed in lieu of Res. 109, A-12 Reaffirmed in lieu of Res. 125, A-12 Reaffirmed: Res. 239, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmation: A-17 Reaffirmed: Res. 518, A-17)

H-185.964 Status Report on the Uninsured
Our AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99 Reaffirmed: CMS Rep. 5, A-09)

H-410.961 Adding a Disclaimer to Clinical Practice Guidelines
Our AMA recommends that all specialty and subspecialty societies the placement of a disclaimer on each clinical practice guideline reaffirming that guidelines are not a substitute for the experience and judgment of a physician and are developed to enhance the physicians' ability to practice evidence-based medicine. (Res. 806, A-02 Reaffirmation A-06 Reaffirmed: CMS Rep. 01, A-16)

H-410.997 Practice Parameters and Review Criteria
Our AMA believes that variations from medical practice guidelines and parameters are not, except in very limited circumstances, per se indicators of quality or medical necessity problems. Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality or payment denials. Otherwise, variations from the guidelines and parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues. (Consolidated by CMS Rep. 8, I-96 Reaffirmed and Modified: CSAPH Rep. 3, A-06 Reaffirmed: CMS Rep. 01, A-16)

Health Care Standards H-450.935
Our AMA: (1) supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy or current or new diagnostic or therapeutic tests, procedures, medications or other procedures that improve the quality of patient care; (2) supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment; (3) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or

similar set of principles or clinical recommendations, to include a statement that they are guidelines only; and (4) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines. (Res. 205, A-10 Reaffirmation I-10)

(18) RESOLUTION 118 - PAYMENT FOR ADVANCE CARE PLANNING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-390.916 be reaffirmed in lieu of Resolution 118.

Resolution 118 asks that our AMA seek federal legislation to require Medicare Advantage, Medicaid, and commercial insurance to pay for advance care planning whenever the patient's physician believes that it is appropriate.

Your Reference Committee heard limited testimony on Resolution 118. Speakers noted that existing policy addresses the intent of the resolution, including a member of the Council on Medical Service. Your Reference Committee agrees that existing AMA policy appropriately responds to the issues raised in Resolution 118, and can be used to support future advocacy efforts. As such, your Reference Committee recommends that Policy H-390.916 be reaffirmed in lieu of Resolution 118.

H-390.916 Payment for Patient Counseling Regarding Advance Care Planning
Our AMA encourages all public and private health insurers to be required to pay, at a reasonable payment rate, for counseling with patients and/or relatives and guardians regarding advance care planning, including goals of care, as an accepted and integral part of good medical care, particularly as it relates to the discussion of advance directives (e.g., living wills and durable powers of attorney for health care). (Res. 1, I-90; Reaffirmed: Sunset Report, I-00; Modified in lieu of Res. 101, A-07; Reaffirmation A-09; Modified: Res. 107, A-15)

(19) RESOLUTION 119 - PAYMENT FOR PALLIATIVE CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-70.915, H-85.951 and H-85.966 be reaffirmed in lieu of Resolution 119.

Resolution 119 asks that our AMA seek federal legislation to require Medicare, Medicare Advantage, Medicaid, and commercial insurance to pay for palliative care, regardless of site of care, whenever the patient's physician believes that it is appropriate and the patient, or surrogate decision maker, agrees.

Your Reference Committee heard limited yet mixed testimony on Resolution 119. There was a call for referral. Importantly, testimony from the Council on Medical Service highlighted that existing policy addresses the intent of Resolution 119. Your Reference Committee agrees, and as such recommends that Policies H-70.915, H-85.951 and H-85.966 be reaffirmed in lieu of Resolution 119.

H-70.915 Good Palliative Care
Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them. (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16)

H-85.951 Concurrent Hospice and Curative Care
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care. 2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services. 3. Our AMA encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly. (CMS Rep. 04, I-16)

H-85.966 Hospice Coverage and Underutilization
The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue

to treat the underlying malignant disease, if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life. (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16)

Madam Speaker, this concludes the report of Reference Committee A. I would like to thank Lase Ajayi, MD, Peter Aran, MD, Micah Beachy, DO, Christine Pabin Bishof, MD, Maryanne Bombaugh, MD, Beverly Collins, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, Julie Marder, JD, and Rebecca Gierhahn, MS.

Toluwalase Ajayi, MD
American Academy of Pediatrics

Christine Pabin Bishof, MD (Alternate)
Illinois

Peter Aran, MD (Alternate)
Oklahoma

Maryanne Bombaugh, MD
Massachusetts

Micah Beachy, DO
American College of Physicians

Beverly A. Collins, MD (Alternate)
American College of Medical Quality

Jonathan D. Leffert, MD
American Association of Clinical Endocrinologists
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee B

R. Dale Blasier, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 14 – Integration of Drug Price Information into Electronic Medical Records/Barriers to Price Transparency/Bidirectional Communication for EHR Software and Pharmacies/Health Plan, Pharmacy, Electronic Health Records Integration (Resolution 219-A-17; Resolution 213-I-17; Resolution 203-I-17; Resolution 205-I-17)
2. Board of Trustees Report 15 – Advanced Practice Registered Nurse Compact
3. Board of Trustees Report 16 – Protection of Clinician-Patient Privilege (Resolution 237-A-17)
4. Board of Trustees Report 18 – Medical Liability Coverage Through the Federal Tort Claims Act (Resolution 214-A-17)
5. Board of Trustees Report 19 – Health Information Technology Principles (Resolution 218-I-17)
6. Board of Trustees Report 44 – CMS Reimbursement Guidelines for Teaching Physician Supervision (Resolution 230-A-17)
7. Board of Trustees Report 45 – Licensing of Electronic Health Records (Resolution 218-A-17)
8. Resolution 203 – Updating Federal Food Policy to Improve Nutrition and Health
9. Resolution 204 – Opposition to Mandated Proficiency in EHR for Licensure
10. Resolution 216 – FDA Conflict of Interest
11. Resolution 221 – Maintaining Validity and Comprehensiveness of U.S. Census Data
12. Resolution 232 – Recording Law Reform
13. Resolution 233 – Support for Reauthorization of the Supplemental Nutrition Assistance Program

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

14. Resolution 253 – Separation of Children from their Parents at Border
    Resolution 257 – Separation of Children from their Parents at Border

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

15. Board of Trustees Report 9 – Council on Legislation Sunset Review of 2008 House Policies
16. Board of Trustees Report 12 – Advocacy for Seamless Interface between Physician Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17)
    Resolution 237 – Safe and Efficient E-Prescribing

17. Board of Trustees Report 17 – Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care
18. Board of Trustees Report 41 – Augmented Intelligence (AI) in Health Care
Resolution 205 – Augmented Intelligence
19. Resolution 201 – Barriers to Obesity Treatment
20. Resolution 202 – Universal and Standardized Protocols for EHR Data Transition
21. Resolution 208 – Prior Authorization Requirements for Post-Operative Opioids
22. Resolution 209 – Substance Use Disorders During Pregnancy
23. Resolution 211 – Clarification from US Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws
24. Resolution 215 – Regulation of Hospital Advertising
25. Resolution 218 – Considering Feminine Hygiene Products as Medical Necessities
26. Resolution 222 – Evidence Based Treatment in Substance Abuse Treatment Facilities
Resolution 240 – Treating Opioid Use Disorder in Treatment Facilities
27. Resolution 223 – Treating Opioid Use Disorder in Hospitals
Resolution 239 – Treating Opioid Use Disorder in Hospitals
28. Resolution 224 – Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions
29. Resolution 225 – Pharmacy Benefit Managers Impact on Patients
30. Resolution 229 – Green Card Backlog for Immigrant Doctors on H-1B Visa
31. Resolution 230 – Opposition to Funding Cuts for Programs that Impact the Health of Populations
32. Resolution 231 – Online Controlled Drugs
33. Resolution 236 – Reducing MIPS Reporting Burden
34. Resolution 241 – Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies
35. Resolution 242 – Pharmacy Benefit Managers and Compounded Medications
36. Resolution 243 – Report Health Care Provider Sex Crimes to Law Enforcement
37. Resolution 244 – Increasing the Legal Age of Purchasing Ammunition and Firearms From 18 to 21
Resolution 248 – Opposition to Firearm Concealed Carry Reciprocity
38. Resolution 245 – Opposing NCOIL Attempts to Stop Physician Dispensing
39. Resolution 246 – Support for Patients and Physicians in Direct Primary Care
40. Resolution 247 – Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program
41. Resolution 250 – Clarification of Guidelines for Online
42. Resolution 251 – Scope of Practice Expansion Advocacy and Impacts on Physicians and Medical Students
43. Resolution 254 – Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services
44. Resolution 255 – 340B Drug Discount Program
45. Resolution 256 – Federal Aviation Administration BasicMed Exams to be Done by Physicians with Prescriptive Authority

RECOMMENDED FOR REFERRAL

46. Resolution 217 – Reforming the Orphan Drug Act
Resolution 227 – An Optional National Prescription Drug Formulary

Resolution 238 – Reform of Pharmaceutical Pricing: Negotiated Payment Schedules

47. Resolution 226 – Model State Legislation for Routine Preventative Prostate Cancer Screening for Men Ages 55-69
48. Resolution 235 – Hospital Consolidation
49. Resolution 252 – Repeal of Group Purchasing Organizations and Pharmacy Benefit Managers

RECOMMENDED FOR REFERRAL FOR DECISION

50. Resolution 219 – Improving Medicare Patients' Access to Kidney Transplantation

RECOMMENDED FOR NOT ADOPTION

51. Resolution 212 – Value-Based Payment System
52. Resolution 249 – Support Any Willing Provider Legislation

RECOMMENDED FOR FILING

53. Board of Trustees Report 21 – Ownership of Patient Data

The following resolutions were included on the Reaffirmation Consent Calendar and were not addressed by the Reference Committee:

Resolution 206 – Appropriate Use of Telehealth Services
Resolution 207 – Quality Improvement Requirements
Resolution 210 – Banning the Sale of Bump Stocks
Resolution 213 – Utilization Review
Resolution 214 – Strengthening the Background Check System for Firearm Sales
Resolution 220 – Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines
Resolution 228 – Medicare Quality Incentives
Resolution 234 – Support for the Primary Care Enhancement Act

(1) BOARD OF TRUSTEES REPORT 14 – INTEGRATION OF DRUG PRICE INFORMATION INTO ELECTRONIC MEDICAL RECORDS/BARRIERS TO PRICE TRANSPARENCY/BIDIRECTIONAL COMMUNICATION FOR EHR SOFTWARE AND PHARMACIES/HEALTH PLAN, PHARMACY, ELECTRONIC HEALTH RECORDS INTEGRATION (RESOLUTION 219-A-17; RESOLUTION 213-I-17; RESOLUTION 203-1-17; RESOLUTION 205-1-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 14 be adopted and the remainder of the report be filed.

The BOT recommends that: the following be adopted in lieu of Resolutions 219-A-17, 203-I-17, 205-I-17, and 213-I-17, and that the remainder of the report be filed, 1. That our American Medical Association reaffirm Policies H-110.988, "Controlling the Skyrocketing Costs of Generic Prescription Drugs," H-110.997, "Cost of Prescription Drugs," D-155.987, "Price Transparency," H-110.987, "Pharmaceutical Costs," and H-110.991, "Price of Medicine;" (Reaffirm HOD Policy)

2. That our AMA collaborate with other interested stakeholders to explore (a) current availability and accessibility of EHR, pharmacy and payer functionalities that enable integration of price, insurance coverage, formulary tier and drug utilization management policies, and patient cost information at the point of care, (b) at what levels barriers exist to this functionality or access, and (c) what is currently being done to address these barriers; (Directive to Take Action), 3. That our AMA collaborate with other interested stakeholders to develop and implement a strategic plan for improving the availability and accessibility of real-time prescription cost information at the point of care. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Board of Trustees Report 14. Your Reference Committee heard testimony that integrating drug price and cost information into electronic health records will help improve drug price transparency and ultimately facilitate better-informed, shared treatment decisions that could help reduce prescription drug spending. Your Reference Committee also heard testimony that our AMA should work with stakeholders to address the barriers and complexities surrounding this issue and to also develop a strategic plan to improve the availability and accessibility of real-time prescription cost information. Accordingly, your Reference Committee recommends adoption.

(2) BOARD OF TRUSTEES REPORT 15 – ADVANCED PRACTICE REGISTERED NURSE COMPACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 15 be adopted and the remainder of the report be filed.

The BOT recommends that: AMA Policy H-35.988(2), "Independent Practice of Medicine by Advanced Practice Registered Nurses," be rescinded and that the remainder of this report be filed. (Rescind HOD Policy)

Your Reference Committee heard testimony in support of Board of Trustees Report 15. Your Reference Committee also heard that the Scope of Practice Summit resulting from AMA Policy H-35.988 was timely and strategic, and presented a welcome opportunity to discuss scope of practice trends and priorities. Your Reference Committee understands that conversations about potential advocacy strategies and resources will be ongoing and will continue to take place through AMA meetings dedicated to advocacy and scope of practice, as well as through the Scope of Practice Partnership (SOPP). Your Reference Committee heard great appreciation for the ample scope of practice resources our AMA provide through its Advocacy Resource Center and the combined efforts of the SOPP. Your Reference Committee commends our AMA on a successful Scope of Practice Summit, and recommends that Board of Trustees Report 15 be adopted.

(3) BOARD OF TRUSTEES REPORT 16 – PROTECTION OF CLINICIAN-PATIENT PRIVILEGE (RESOLUTION 237-A-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 16 be adopted and the remainder of the report be filed.

The BOT recommends that: AMA Policy H-315.983 be amended in lieu of Resolution 237-A-17 and the remainder of the report be filed: Policy H-315.983, "Patient Privacy and Confidentiality," 1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; ~~and~~ (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. (Modify Current HOD Policy)

Your Reference Committee heard limited but supportive testimony on Board of Trustees Report 16. Your Reference Committee heard testimony that regardless of the clinical care setting that HIPAA's privacy protections should be the minimal level of privacy afforded to a patient. Accordingly, your Reference Committee recommends adoption of Board Report 16.

(4) BOARD OF TRUSTEES REPORT 18 – MEDICAL LIABILITY COVERAGE THROUGH THE FEDERAL TORT CLAIMS ACT (RESOLUTION 214-A-17).

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 18 be adopted and the remainder of the report be filed.

The BOT recommends that: Resolution 214-A-17 not be adopted and the remainder of the report be filed.

Your Reference Committee heard generally supportive testimony on Board of Trustees Report 18. Your Reference Committee heard testimony that application of the Federal Tort Claims Act to all federal health programs would result in physicians having no control over the direction of a medical liability case, be a broad overreach and significant departure from Congressional intent, and conflict with strong AMA policy where our AMA cannot support federal preemptive legislation that would undermine effective state tort reform efforts. For all the reasons articulated in a thorough and extensive Board of Trustees Report, your Reference Committee recommends that Board of Trustees Report 18 be adopted.

(5) BOARD OF TRUSTEES REPORT 19 – HEALTH INFORMATION TECHNOLOGY PRINCIPLES (RESOLUTION 218-I-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends the recommendation in Board of Trustees Report 19 be adopted and the remainder of the report be filed.

The BOT recommends that: our American Medical Association adopt the following in lieu of Resolution 218-I-17, and the remainder of this report be filed, 1. That the following policies be reaffirmed: H-480.971, "The Computer-Based Patient Record," D-478.972, "EHR Interoperability," D-478.973, "Principles for Hospital Sponsored Electronic Health Records," D-478.994, "Health Information Technology," D-478.995, "National Health Information Technology," D-478.996, "Information Technology Standards and Costs" (Reaffirm HOD Policy), 2. That our AMA promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should: 1. Enhance physicians' ability to provide high quality patient care; 2. Support team-based care; 3. Promote care coordination; 4. Offer product modularity and configurability; 5. Reduce cognitive workload; 6. Promote data

liquidity; 7. Facilitate digital and mobile patient engagement; and 8. Expedite user input into product design and post-implementation feedback. (New HOD 24 Policy) 3. That our AMA utilize HIT principles to: 1. Work with vendors to foster the development of usable EHRs; 2. Advocate to federal and state policymakers to develop effective HIT policy; 3. Collaborate with institutions and health care systems to develop effective institutional HIT policies; 4. Partner with researchers to advance our understanding of HIT usability; and 5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 19. Your Reference Committee agrees with testimony that health information technology has numerous usability and security issues that have negatively impacted the physician-user experience. Your Reference Committee also heard testimony that our AMA released EHR usability priorities in 2014. These priorities have successfully guided our AMA's advocacy efforts including requiring real-world testing of EHRs, disclosing of EHR vendors fees, and prohibiting restrictions on user communications about EHR usability. Your Reference Committee believes that our Board had the opportunity to fully discern this issue of reconciling original Resolution 218-1-17 with our AMA policy and in conjunction with the usability priorities with the including principle eight from the original Resolution, which essentially asks our AMA to take a position that payers are responsible for reimbursing physicians for the costs associated with implementing EHR systems. Additionally, our AMA previously elected to not adopt a similar resolution (831-I-16), instead resolving to focus on encouraging vendors and payers to actively work toward better, more user-friendly and cost-effective solutions that do not overburden physicians and practices. Your Reference Committee further heard testimony that our AMA should adopt these successful priorities into AMA policy. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 19.

(6) BOARD OF TRUSTEES REPORT 44 – CMS REIMBURSEMENT GUIDELINES FOR TEACHING PHYSICIAN SUPERVISION (RESOLUTION 230-A-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 44 be adopted and the remainder of the report filed.

The Board of Trustees recommends that Resolution 230-A-17 be adopted and the remainder of this report be filed.

Your Reference Committee heard supportive testimony on Board of Trustees Report 44. Your Reference Committee heard that it is not logical to treat major and minor procedures differently based solely on the length of the procedure. Your Reference Committee also heard testimony that procedures should be treated the same regardless of the length of time the procedure takes. Your Reference Committee agrees and accordingly recommends adoption of Board of Trustees Report 44.

(7) BOARD OF TRUSTEES REPORT 45 – LICENSING OF ELECTRONIC HEALTH RECORDS (RESOLUTION 218-A-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 45 be adopted and the remainder of the report be filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 218-A-17 and the remainder of the report be filed: 1. That our American Medical Association (AMA) continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care. (Directive to Take Action) 2. That our AMA reaffirm Policies D-460.968, D-478.972, D-478.973, D-478.994, D-478.995, and D-478.996, which broadly direct AMA to continue its leadership in efforts to define and promote standards that facilitate the interoperability of Electronic Health Records (EHRs); to advocate for improvements to EHRs that will enable interoperability and access while not creating additional burdens and usability challenges for physicians; and to advocate for physician flexibility for the adoption and use of certified EHRs and to not financially penalize physicians for using certified EHRs technology that does not meet current standards. (Reaffirm HOD Policy)

Your Reference Committee heard limited testimony on Board of Trustees Report 45. Your Reference Committee heard testimony that our AMA should continue leading efforts to advance policies to improve the usability and interoperability of EHRs in lieu of developing model legislation to license EHRs. Accordingly, your Reference Committee recommends that Board of Trustees Report 45 be adopted and the rest of the report be filed.

(8) RESOLUTION 203 – UPDATING FEDERAL FOOD POLICY TO IMPROVE NUTRITION AND HEALTH

RECOMMENDATION:

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

Resolution 203 asks that our American Medical Association amend existing AMA Policy D-440.978, 26 “Culturally Responsive Dietary and Nutritional Guidelines,” by addition to read as follows: D-440.978 Culturally Responsive Dietary and Nutritional Guidelines. Our AMA and its Minority Affairs Section will: (1) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (2) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (3) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and ~~(34)~~ monitor existing research and identify opportunities where organized medicine can

impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (Modify Current HOD Policy); and be it further that our AMA propose legislation that modifies the National School Lunch Act, 42 U.S.C. § 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cow's milk (Directive to Take Action); and be it further that our AMA recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, rather than recommended or required. (New HOD Policy)

Your Reference Committee heard overwhelming supportive testimony on Resolution 203. Testimony was presented that lactose intolerance is a common condition among African Americans, Asian Americans, and Native Americans. Your Reference Committee also heard testimony that African Americans are at particularly high risk for prostate cancer, colorectal cancer, and cardiovascular mortality, and that prostate and colorectal cancer are strongly linked to dairy and meat consumption, respectively, which are promoted in federal nutrition policies. Accordingly, your Reference Committee recommends that Resolution 203 be adopted.

(9) RESOLUTION 204 – OPPOSITION TO MANDATED PROFICIENCY IN ELECTRONIC HEALTH RECORDS FOR LICENSURE

RECOMMENDATION:

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

Resolution 204 asks that our American Medical Association adopt a policy that provides that no physician should be denied a medical license on the grounds of failure to use an electronic health record or failure to demonstrate proficiency in use of an electronic health record. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 204. Your Reference Committee heard testimony that Resolution 204 is in line with existing AMA policy that licensing laws should relate only to requirements for the practice of medicine. Accordingly, your Reference Committee recommends that Resolution 204 be adopted.

(10) RESOLUTION 216 – FDA CONFLICT OF INTEREST

RECOMMENDATION:

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

Resolution 216 asks that our American Medical Association advocate that the Food and Drug Administration place a greater emphasis on a candidate's conflict of interest when selecting members for advisory committees (New HOD Policy); and be it further , that

our AMA advocate for a reduction in conflict of interest waivers granted to Advisory Committee candidates. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 216. Your Reference Committee heard testimony that industry funding of FDA activities and the regular interactions that occur between industry and the FDA that frequently do not include the participation or representation of the physician community. Your Reference Committee believes that disclosure and transparency into conflicts is important and that challenges may exist to find qualified individuals without conflicts with industry. However, your Reference Committee also heard testimony that the FDA advisory committees should utilize generally accepted conflicts of interest policies and should limit waivers of such policies. Accordingly, your Reference Committee recommends adoption of Resolution 216.

(11) RESOLUTION 221 – MAINTAINING VALIDITY AND COMPREHENSIVENESS OF U.S. CENSUS DATA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 221 be adopted.

Resolution 221 asks that our American Medical Association support adequate funding for the U.S. Census to assure accurate and relevant data is collected and disseminated. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 221. Your Reference Committee heard about the importance of the U.S. Census in determining the allocation of more than $675 billion in federal funding to states and communities annually. Additional testimony noted that these funds are used for community development, public health, education, transportation, and other community resource investments that are critical to decreasing the health, social, and economic disparities experienced by vulnerable populations. Your Reference Committee also heard that an inaccurate count during the 2020 Census would have significant consequences as the demographic data from the count are the basis for surveys that are benchmarks for major businesses, governments, and researchers, and would affect the distribution of funding to states and communities across the nation for community development, public health, education, transportation, and other community resource investments. Your Reference Committee notes that while our AMA has no policy related to the U.S. Census, our AMA has numerous policies related to addressing health disparities experienced by vulnerable populations, including Hispanics, African-Americans, American Indians, and women. Your Reference Committee believes that adoption of this resolution would be consistent with the goals of these policies. Your Reference Committee recognizes that the author of Resolution 221 offered a second resolved regarding a citizenship question on the 2020 Census. Your Reference Committee heard testimony both for and against this amendment; however, your Reference Committee does not believe that it has sufficient information or the expertise to make an informed recommendation. Therefore, your Reference Committee recommends adoption of Resolution 221.

(12) RESOLUTION 232 – RECORDING LAW REFORM

RECOMMENDATION:

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

Resolution 232 asks that our American Medical Association draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation. (Directive to Take Action)

Your Reference Committee heard overwhelming supportive testimony on Resolution 232. Your Reference Committee heard testimony that the physician-patient relationship is sacred and based on trust. Your Reference Committee also heard testimony that Resolution 232 further supports the physician-patient relationship and helps foster greater trust between a physician and a patient. Your Reference Committee agrees with the testimony and recommends adoption.

(13) RESOLUTION 233 – SUPPORT FOR REAUTHORIZATION OF THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

RECOMMENDATION:

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

Resolution 233 asks that our American Medical Association actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives (Directive to Take Action); and be it further, that AMA Policy D-150.975, which calls for action to remove sugar-sweetened beverages from the Supplemental Nutrition Assistance Program, be reaffirmed (Reaffirm HOD Policy); and be it further, that AMA Policy H-150.937, which in part aims to replace calorie-rich, nutrient-poor food with nutrient-dense food within the Supplemental Nutrition Assistance Program, be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 233. Your Reference Committee heard testimony that the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) is the country's most effective anti-hunger program with most SNAP participants being children, seniors, or people with disabilities. Your Reference Committee also heard testimony that SNAP is reauthorized through the Farm Bill, which is being reauthorized this year. The proposed changes to SNAP are projected to result in more than 1 million low-income households with more than 2 million people losing their benefits altogether or have them reduced. Your Reference Committee understands that our AMA has policy related to SNAP and improvements to the program, but our AMA does not currently have policy directing our AMA to actively lobby Congress to preserve and protect SNAP through the reauthorization of the 2018 Farm Bill. Accordingly, your Reference Committee recommends adoption of Resolution 233.

(14) RESOLUTION 253 – SEPARATION OF CHILDREN FROM THEIR PARENTS AT BORDER
RESOLUTION 257 – SEPARATION OF CHILDREN FROM THEIR PARENTS AT BORDER

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends adopting Resolution 253 in lieu of Resolution 257.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 253 be changed to read as follows:

SEPARATION OF CHILDREN FROM THEIR CAREGIVERS AT THE BORDER

Resolution 253 asks that our AMA oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and be it further (New HOD Policy), that our AMA urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families (Directive to Take Action). Resolution 257 asks that our American Medical Association urge the Department of Homeland Security, Attorney General Sessions, and President Trump to withdraw its new policy to require separation of children from their parents, and instead, give priority to supporting families and protecting the health and well-being of the children within those families. (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 253 and Resolution 257. Your Reference Committee heard testimony that separating children from their parents entering the United States will cause harm to children, parents, and their families. Testimony also stated that childhood trauma and adverse childhood experiences create negative health impacts that could last an individual's entire lifespan. Your Reference Committee further heard testimony that our AMA has policy that opposes the separation of parents from their children who are detained while seeking safe haven. Your Reference Committee heard testimony that Resolution 253 should be amended to use the term caregivers in the title to be consistent with the content of the resolution. Accordingly, your Reference Committee recommends adoption of Resolution 253 with amendment and in lieu of Resolution 257.

(15) BOARD OF TRUSTEES REPORT 9 – COUNCIL ON LEGISLATION SUNSET REVIEW OF 2008 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be amended by addition to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, except for Policy H-270.965, which should be rescinded, and Policy H-315.977, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be adopted as amended and that the remainder of the report be filed.

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

Your Reference Committee heard and agreed with testimony urging that Policy H-270.965 be rescinded, and that Policy H-315.977 be retained. Therefore, your Reference Committee recommends that the recommendation of Board of Trustees Report 9 be adopted as amended and that the remainder of the report be filed.

(16) BOARD OF TRUSTEES REPORT 12 – ADVOCACY FOR SEAMLESS INTERFACE BETWEEN ELECTRONIC HEALTH RECORDS, PHARMACIES, AND PRESCRIPTION DRUG MONITORING PROGRAMS (RESOLUTION 212-A-17)
RESOLUTION 237 – SAFE AND EFFICIENT E-PRESCRIBING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 12 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use

disorders as part of medication assisted treatment with counseling. This would include identifying whether ~~how~~ PDMPs can distinguish team-based care from uncoordinated care, misuse, or "doctor shopping," as well as whether PDMPs help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of the Board of Trustees Report 12 be adopted as amended in lieu of Resolution 237 and the remainder of the report be filed.

The Board of Trustees recommends that: the following recommendations be adopted in lieu of Resolution 212-A-17: 1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish team-based care from uncoordinated care, misuse, or "doctor shopping," as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action), 2. That our AMA urge EHR vendors to increase transparency of custom connections between their products and PDMP software. (Directive to Take Action), 3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD Policy) Resolution 237 asks that our American Medical Association study current e-prescribing processes and make recommendations to improve these processes to make them as safe as possible for patients and as efficient as possible for prescribers. (Directive to Take Action).

Your Reference Committee heard support for using prescription drug monitoring programs (PDMPs), electronic health records (EHRs), and electronic prescribing of controlled substances (EPCS). Your Reference Committee agrees with testimony that treatment for evidence-based treatment substance use disorders includes medication assisted treatment with counseling. Your Reference Committee appreciates the fact that physicians are increasingly using PDMPs, EHRs and EPCS, but as noted by the Board in its report, there often are significant barriers to using these tools effectively in practice. The Board's recommendations would help identify those barriers in a comprehensive manner as an important step in reversing the nation's opioid epidemic. Moreover, your Reference Committee appreciates comments that the first question is whether these tools are, in fact, working as intended. At a time when policy development is accelerating at a rapid pace, it is important to know whether those policies impede clinical practice.

(17) BOARD OF TRUSTEES REPORT 17 – EVALUATING ACTIONS BY PHARMACY BENEFIT MANAGERS AND PAYER POLICIES ON PATIENT CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation one of Board of Trustees Report 17 be amended by addition and deletion to read as follows:

That our American Medical Association (AMA) urge the National Association of Boards of Pharmacy, ~~and~~ Federation of State Medical Boards (FSMB), and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies, and Pharmacy Benefits Managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards~~, respectively,~~ and state departments of insurance, on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy~~, respectively~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of the Board of Trustees Report 17 be adopted as amended and the remainder of the report be filed.

The BOT recommends that: the remainder of the report be filed. 1. That our American Medical Association (AMA) urge the National Association of Boards of Pharmacy and Federation of State Medical Boards to support having national pharmacy chains, health insurance companies and PBMs testify at state-level public hearings by state/pharmacy boards, respectively, on whether their policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state law governing the practice of medicine and pharmacy, respectively. (Directive to Take Action), 2. That our AMA oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice. (New HOD Policy), 3. That our AMA reaffirm Policy H-95.990, "Drug Abuse Related to Prescribing Practices," which supports cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups as necessary to identify situations where a person is attempting to obtain a prescription for fraudulent or otherwise illegal means. (Reaffirm HOD Policy), 4. That our AMA reaffirm Policy H-95.932, "Increasing Availability of Naloxone," which supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies. (Reaffirm HOD Policy)

Your Reference Committee heard strong support for the recommendations in Board of Trustees Report 17. As background, your Reference Committee points out that the Centers for Disease Control and Prevention's 2016 opioid prescribing guidelines were intended—as CDC has repeatedly said—to be voluntary guidelines largely focused on primary care, acute pain episodes of care. Since then, however, as our Board explains, many state legislatures, health insurance companies, pharmacies and pharmacy benefit management companies have taken the guidelines—or a variation of them—and transformed them into hard policy thresholds, state laws and other requirements. Your Reference Committee agrees that physicians have a responsibility to be leaders in supporting more judicious prescribing habits, and your Reference Committee are pleased that our AMA Opioid Task Force reported a 22.2 percent national decrease in opioid prescribing between 2013 and 2017. Your Reference Committee agrees that specific dose or duration limits on pharmacologic therapy must be supported by medical evidence and clinical practice. Your Reference Committee also agrees that it is time for a close look at how these policies are affecting patients, including whether they are in conflict with state licensing laws that govern the practice of medicine, pharmacy and/or insurance. Your Reference Committee hopes that this dialogue will create much-needed transparency to review the evidence for their policies. For these reasons, your Reference Committee recommends adoption of the recommendations in Board of Trustees Report 17 as amended.

(18) BOARD OF TRUSTEES REPORT 41 – AUGMENTED INTELLIGENCE IN HEALTH CARE
RESOLUTION 205 – AUGMENTED INTELLIGENCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 41 <u>be amended by addition</u> to read as follows:

As a leader in American medicine, our American Medical Association (AMA) has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;

d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
2. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
3. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 41 be adopted as amended in lieu of Resolution 205 and the remainder of the report be filed.

The Board recommends that: the following be adopted and the remainder of this report be filed as a leader in American medicine, our American Medical Association (AMA) has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to: 1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI, 2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI, 3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; b. is transparent; c. conforms to leading standards for reproducibility; d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and e. safeguards individuals' privacy interests and preserves the security and integrity of personal information, 4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI, 5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (New HOD Policy) Resolution 205 asks that our American Medical Association develop Augmented Intelligence (AI) policy that reflects the principle that all patients should have 24-7 access to primary care physicians who can see the medical records of the patients (New HOD Policy); and be it further, that AI should be funded as an enhancement of the primary care medical home so that patients who really need AI can benefit from the technology and such that AI does not

become a requirement that must be incorporated into the care of every patient. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Board Report 41 and mixed testimony on Resolution 205. Your Reference Committee heard testimony that physicians must provide a clear set of policy positions on health care augmented intelligence (AI) and to ensure the best interests of patients are served. Your Reference Committee also heard testimony that while safeguarding individuals' privacy interest is laudable, the focus should be on safeguarding patients' privacy interest. Your Reference Committee believes that Resolution 205 intends to advance important goals of health care AI such as ensuring it is part of workflow, that it is not mandated for use, and it strengthens the medical home. Your Reference Committee believes that Board of Trustees Report 41 captures those goals and ensures that policy addresses other important issues like guarding against bias, applies to specialty care, and explores the legal implications of health care AI.

Your Reference Committee heard further testimony that federal and state legislators and policymakers are already becoming actively engaged in developing laws and regulations on health care AI. Your Reference Committee agrees with testimony that physicians have a critical perspective and must engage now to ensure this technology develops and is integrated to improve patient outcomes, reduce administrative and technological burdens, and supports physician satisfaction. Your Reference Committee heard testimony offering an amendment to safeguard patients' and individuals' privacy interests. Accordingly, your Reference Committee recommends adoption of Board Report 41 with amendment in lieu of Resolution 205.

(19) RESOLUTION 201 – BARRIERS TO OBESITY TREATMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 201 be <u>adopted</u>.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 201 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA ~~actively lobby~~<u>work</u> with <u>interested</u> state medical societies and other ~~interested~~ stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 201 be adopted as amended.

Resolution 201 asks that our American Medical Association work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment (Directive to Take Action); and be it further, that our AMA actively lobby with state medical societies and other interested stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 201. Your Reference Committee heard testimony that there are many evidence-based, effective and safe treatment options for obesity. Those testifying expressed an appreciation for existing AMA policy, which recognizes that obesity requires a range of interventions to advance obesity treatment and prevention and directs our AMA to work with specialty and state medical societies to advocate for patient access to the full continuum of evidence-based treatment modalities. Your Reference Committee heard, however, of the need to build on existing policy to ensure the elimination of barriers to obesity treatment that is consistent with the standard of care. Your Reference Committee recommends a minor amendment to reflect that AMA direct engagement in state legislative affairs occurs only with the approval of state medical associations. Your Reference Committee, therefore, recommends that Resolution 201 be adopted as amended.

(20) RESOLUTION 202 – UNIVERSAL AND STANDARDIZED PROTOCOLS FOR EHR DATA TRANSITION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 202 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols ~~required universal and standard protocols~~ for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data. (Directive to Take Action)

RECOMMENDATION B:

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

Resolution 202 asks that our American Medical Association seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish required universal and standard protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 202. Your Reference Committee heard testimony that switching EHR vendors can be costly and disruptive to patient care. Your Reference Committee also heard testimony that without standard methods or protocols to transfer data among EHR vendors, physician and health systems may be effectively required to continue to use the current EHR vendors. Testimony supporting amendment to Resolution 202 included implementing non-charged upgrades/updates to EHR systems during an EHR data transitions and also imposed specific deadlines of regulatory implementation. Your Reference Committee believes that it may be difficult for any regulation to carve out an interoperability update from a regular EHR update. Moreover, your Reference Committee believes that vendors could just shift costs somewhere else like monthly “service” fees or more exorbitant start-up costs. Your Reference Committee further believes that imposing artificial deadlines without knowing the technical standards or proper testing of those standards may further inhibit interoperability and increase physician frustration. Accordingly, your Reference Committee recommends adopting Resolution 202 as amended.

(21) RESOLUTION 208 – PRIOR AUTHORIZATION REQUIREMENTS FOR POST-OPERATIVE OPIOIDS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 208 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our American Medical Association strongly oppose prior authorization requirements for post-operative analgesia ~~equivalent to five days or less~~ so as to prevent patient suffering.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be <u>adopted as amended</u>.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the <u>title</u> of Resolution 208 be <u>changed</u> to read as follows:

PRIOR AUTHORIZATION REQUIREMENTS FOR POST OPERATIVE ANALGESIA

Resolution 208 asks that our American Medical Association strongly oppose prior authorization requirements for postoperative analgesia equivalent to five days or less so as to prevent patient suffering. (New HOD Policy)

Your Reference Committee heard extended testimony on Resolution 208. Your Reference Committee heard clear support that prior authorization policies for a "five-day" limit on post-operative opioids are often a barrier to care for patients requiring adequate pain relief. Testimony highlighted the individual characteristics of the type of surgical intervention and unique characteristics of the patient should be the determining factor in whether an opioid—or other pharmacologic—option is most appropriate. Your Reference Committee notes that Board of Trustees Report 17 also discussed the need for any dose or duration requirement to be based on clinical evidence and medical practice. Your Reference Committee agrees with our Board that our AMA should not support arbitrary thresholds or guidelines for any medical practice. Rather, your Reference Committee agrees with testimony that the practice of medicine be governed by the best medical evidence and evolving clinical practice. And while your Reference Committee acknowledges that prior authorization for many medical, pharmacologic, and non-pharmacologic therapies are adversely affected by disruptive prior authorization policies, your Reference Committee did not expand the scope of the resolution beyond the author's intent. Accordingly, your Reference Committee recommends that Resolution 208 be adopted with amendment by deletion and a change in title.

(22) RESOLUTION 209 – SUBSTANCE USE DISORDERS DURING PREGNANCY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 209 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA support ~~legislation~~ <u>legislative and other appropriate efforts</u> for the expansion and improved access to evidence-based treatment for substance ~~ab~~use disorders during pregnancy ~~without mandating any specific form of therapy~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 209 be <u>adopted as amended</u>.

Resolution 209 asks that our American Medical Association (AMA) reaffirm Policy H-420.969 (#4) so as to oppose any legislation that seeks to specifically penalize women who are diagnosed with a substance abuse disorder during pregnancy (Reaffirm HOD Policy); and be it further, that our AMA oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse (New HOD Policy); and be it further, that our AMA support legislation for the expansion and improved access to evidence-based treatment for substance abuse disorders during pregnancy without mandating any specific form of therapy. (Directive to Take Action)

Your Reference Committee heard clear testimony in support of longstanding AMA policy that pregnant women should not be penalized for having a medical disease. Rather, your Reference Committee heard testimony that our AMA should continue its efforts in support of all persons with a substance use disorder from facing criminal penalties or punitive measures as a result of having a substance use disorder. Your Reference Committee emphasizes that this does not suggest in any way that the our AMA condones criminal activity or drug use during pregnancy—simply that the focus on treatment for substance use disorders must remain squarely in the medical realm, with a clear focus on supporting treatment based on the best medical evidence. This resolution accomplishes that goal. Your Reference Committee further heard testimony that Resolution 209 should be amended to reflect current medical terminology and to provide our AMA with more flexibility and avenues to achieve Resolution 209. For these reasons, your Reference Committee recommends adopting the resolution as amended.

(23) RESOLUTION 211 – CLARIFICATION FROM US DEPARTMENT OF JUSTICE REGARDING FEDERAL ENFORCEMENT OF MEDICAL MARIJUANA LAWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 211 be amended by addition to read as follows:

RESOLVED, That our American Medical Association when necessary and prudent seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 211 by adopted as amended.

Resolution 211 asks that our American Medical Association seek clarification from the United States Justice Department about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, provide guidance to physicians. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 211. Your Reference Committee heard testimony that no physicians have been prosecuted yet and that bringing this issue to the Department of Justice may inadvertently cause an actual prosecution. Your Reference Committee also heard that our AMA should be provided flexibility to seek clarification when appropriate. Testimony was also provided to clarify who should provide any potential guidance to our AMA members. Your Reference Committee agrees that there is a possibility of federal prosecution of physicians for

prescribing medical marijuana that complies with a state program. Accordingly, your Reference Committee recommends adoption as amended.

(24) RESOLUTION 215 – REGULATION OF HOSPITAL ADVERTISING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-225.994 be amended by addition to read as follows.

Hospital Advertising in Printed and Broadcast Media H-225.994

RESOLVED, In order to prevent medical misinformation, the AMA encourages (1) medical staff participation in hospital administration decisions regarding marketing and advertising and (2) hospital and medical advertising be consistent with federal regulatory standards and with the Code of Medical Ethics.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-225.994 be adopted as amended in lieu of Resolution 215.

Resolution 215 that our American Medical Association advocate for regulations which promote responsible hospital and medical advertising. (New HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 215. Your Reference Committee heard that our AMA supports truth in advertising and keeping patients informed as they are being treated by a health care provider. Your Reference Committee also heard that the Code of Medical Ethics Opinion 9.6.1 clearly lays out the principles of medical ethics surrounding physician advertising, although it does not specifically speak to hospital advertising. In addition, your Reference Committee heard that, under existing AMA Policy H-225.994, our AMA encourages medical staff participation in hospital administration decisions regarding marketing and advertising to prevent medical misinformation. Testimony supported amending this policy to include language ensuring that hospital and medical advertising be consistent with federal regulatory standards and with the Code of Medical Ethics. Your Reference Committee agrees and recommends that AMA Policy H-225.994 be adopted as amended in lieu of Resolution 215.

(25) RESOLUTION 218 – CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association work with state and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women have affordable access to the appropriate type and quantity of feminine hygiene products including tampons for their needs.

RECOMMENDATION B:

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

Resolution 218 asks that our American Medical Association encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities. (New HOD Policy).

Your Reference Committee heard supportive testimony on Resolution 218. Your Reference Committee heard that, under current Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from a Flexible Spending Account (FSA) or other tax-favored health plan when a licensed health care provider certifies that they are medically necessary. Your Reference Committee heard that the IRS deems feminine hygiene products as items which are not required for treatment, prevention, or diagnosis of a medical condition and are therefore not eligible for reimbursement with an FSA or similar program, nor are these products allowable under the tax-deductions for allowable medical expenses. Testimony also noted that Resolution 218 is consistent with existing AMA policy H-270.953, Tax Exemptions for Feminine Hygiene Products, which supports legislation to remove all sales tax on feminine hygiene products. An amendment was offered that would add a second resolve that would call on our AMA to ensure that incarcerated women have affordable access to feminine hygiene products. Your Reference Committee agrees and accordingly recommends that Resolution 218 be adopted as amended.

(26) RESOLUTION 222 – EVIDENCE BASED TREATMENT IN SUBSTANCE ABUSE TREATMENT FACILITIES
RESOLUTION 240 – TREATING OPIOID USE DISORDER IN TREATMENT FACILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends the adoption of the following resolution in lieu of Resolutions 222 and 240.

SUPPORT THE ELIMINATION OF BARRIERS TO MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDER

RESOLVED, That our American Medical Association advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities (New HOD Policy); and be it further

RESOLVED, That our AMA develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease. (Directive to Take Action)

Resolution 222 asks that our American Medical Association advocate for legislation that eliminates barriers to, increases funding for, and requires access to opioid agonist or partial agonist therapy at all certified drug treatment facilities. (New HOD Policy) Resolution 240 asks that our American Medical Association adopt a policy that recognizes the use of buprenorphine or methadone as effective treatment for opioid use disorder, and encourages the appropriate use of medication and non-medication-based treatment (New HOD Policy); and be it further, that our AMA advocate for legislation to eliminate barriers and require access to all three FDA-approved medications (buprenorphine, methadone and naltrexone) at all legally certified drug treatment facilities, and advocate for standards, policies and funding to support access to these medications at treatment facilities (New HOD Policy); and be it further, that our AMA conduct a campaign to increase awareness on the part of providers, treatment programs, and the public that AMA recognizes the use of buprenorphine or methadone as effective treatment for opioid use disorder. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolutions 222 and 240. There is no question that patients are experiencing delays and denials of care when trying to begin treatment for a substance use disorder. This includes clinics and facilities in the private market as well as those supported by public payers, including correctional settings. Your Reference Committee heard testimony that prior authorization and step therapy requirements can have deadly consequences for patients. In addition, your Reference Committee heard testimony supporting a public awareness campaign to not

only help educate patients, but also to help remove the stigma of having a substance use disorder. Your Reference Committee heard additional testimony offering a substitute resolution that maintains the key concepts of Resolutions 222 and 240. Accordingly, your Reference Committee recommends adopting a substitute resolution that combines the intent of Resolutions 222 and 240.

(27) RESOLUTION 223 – TREATING OPIOID USE DISORDER IN HOSPITALS
RESOLUTION 239 – TREATING OPIOID USE DISORDER IN HOSPITALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 223 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association's Opioid Task Force work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by ~~develop recommendations and an implementation plan to encourage~~ hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease (Directive to Take Action); and be it further

RESOLVED, That our AMA~~'s Opioid Task Force~~ advocate for states to ~~collaborate with relevant organizations to~~ evaluate programs that currently exist or have received ~~seek~~ federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 223 be adopted as amended in lieu of Resolution 239.

Resolution 223 asks that our American Medical Association's Opioid Task Force work together with the American Hospital Association and other relevant organizations to

develop recommendations and an implementation plan to encourage hospitals to treat opioid use disorder as a chronic disease, including identifying patients with this condition; providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; establishing appropriate discharge plans; and participating in community-wide systems of care for patients affected by this chronic disease (Directive to Take Action); and be it further, that our AMA's Opioid Task Force collaborate with relevant organizations to seek federal funding to assist hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder. (Directive to Take Action) Resolution 239 asks that our American Medical Association adopt a policy in favor of hospitals in the United States treating opioid use disorder with medications approved by the U.S. Food and Drug Administration for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling (New HOD Policy); and be it further, that our AMA advocate for legislation, standards, policies and funding to support hospitals in the United States treating opioid use disorder with medications approved by the FDA for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling (New HOD Policy); and be it further, that our AMA work together with relevant organizations such as the American Hospital Association, The Joint Commission and the American Society of Addiction Medicine to develop and promote a model hospital policy that would assist hospitals in addressing opioid use disorder as a chronic disease by: a) ensuring that medical and other clinical staff are educated about evidence-based treatment of opioid use disorder in order to appropriately advise and treat their patients, b) providing patient education about and access to all three FDA-approved medications (buprenorphine, methadone and naltrexone) in emergency and inpatient settings, and buprenorphine and methadone in obstetric settings, c) maintaining use of these medications for patients already on them, d) initiating use of these medications for assenting patients affected by the disease, e) establishing comprehensive discharge plans for ongoing medical and behavioral treatment in the community, and f) participating in the development of community-wide systems of care for patients with opioid use disorder to facilitate discharge planning. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolutions 223 and 239 and the need to evaluate current policies and programs designed to end the nation’s opioid epidemic. Whether those policies and practices exist in hospital or community settings, your Reference Committee agrees with testimony that there is excellent work being done in the nation’s hospitals and in other physician-based and community-based settings. Our AMA Opioid Task Force has earned a strong reputation for convening key medical and other stakeholders to identify best practices and share them widely through our AMA opioid microsite. Your Reference Committee is confident that the Task Force can work with the American Hospital Association (AHA) to identify best practices as well as barriers to care (e.g., practice-related, legal, financial, etc.), including solutions on how to address those barriers. Your Reference Committee also agrees that the nation would be well-served by a thoughtful evaluation of federal- and state-funded efforts to end the epidemic and improve care for patients that is physician-focused. Armed with this information, states can make informed choices about future policy and resource decisions. Your Reference Committee also heard testimony that an amendment to Resolution 223 that maintains the substantive elements of Resolution 239 would ensure consistent and strong policy. This is work that can be done now, which is why your Reference Committee does not support referral. Accordingly, your Reference Committee recommends adoption of Resolution 223 as amended in lieu of Resolution 239.

(28) RESOLUTION 224 – LEGALIZATION OF INTERPHARMACY TRANSFER OF ELECTRONIC PRESCRIPTIONS FOR CONTROLLED SUBSTANCES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for the removal of state, federal and other barriers that impede ~~legalization of~~ interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications. (New HOD Policy)

RECOMMENDATION B:

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

Resolution 224 asks that our American Medical Association advocate for the federal legalization of interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications. (New HOD Policy)

Your Reference Committee heard limited testimony on Resolution 224. Your Reference Committee agrees that there are considerable barriers to widespread adoption of electronic prescribing of controlled substances (EPCS). Our AMA is actively working to remove these barriers, whether technical, practice-specific, or regulatory in nature. Your Reference Committee agrees with the resolution's author intent to broaden the scope of the resolution so as to provide our AMA with additional guidance and flexibility. Accordingly, your Reference Committee recommends adopting Resolution 224 as amended.

(29) RESOLUTION 225 – PHARMACY BENEFIT MANAGERS IMPACT ON PATIENTS

RECOMMENDATION A:

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

RESOLVED, That our AMA examine issues ~~survey the membership about experiences~~ with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 225 be adopted as amended.

Resolution 225 asks that our American Medical Association gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship (Directive to Take Action); and be it further, that our AMA survey the membership about experiences with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony related to the author's proposed amendment to Resolution 225. Specifically, the author recommended that our AMA examine issues with PBM-related clawbacks and direct and indirect renumeration (DIR) fees to better inform our existing AMA advocacy efforts, as opposed to having our AMA survey membership related to their experiences with such clawbacks and DIR fees. Your Reference Committee agrees with testimony that not only will the author's proposed amendment reduce the cost impact (approximately $160,000) of requiring our AMA to field a survey, but also result in the collection of information more helpful to our advocacy in this area. Accordingly, your Reference Committee recommends that Resolution 225 be adopted as amended.

(30) RESOLUTION 229 – GREEN CARD BACKLOG FOR IMMIGRANT DOCTORS ON H-1B VISAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 229:

PERMANENT RESIDENCE STATUS FOR PHYSICIANS ON H1-B VISAS

RESOLVED, That our American Medical Association work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status. (Directive to Take Action)

Resolution 229 asks that our American Medical Association work with the Office of the Inspector General, the Veterans Affairs Administration, United States Citizenship and Immigration Services and the Executive Branch of the United States Government to create a separate path to obtain green cards and citizenship for physicians which would allow these physicians to work unrestricted and allow them to work within the Veterans Affairs Hospital network to address the current and expected future physician shortage in these institutions. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 229. Your Reference Committee heard that there is a sizeable backlog of international medical graduates who are actively practicing in the U.S. and waiting to receive a green card. Your Reference Committee also heard testimony that some physicians have been waiting for decades to receive their green cards due to the per-country numerical limitation for employment-based immigrants in the federal Immigration and Nationality Act. The author of Resolution 229 offered a substitute resolution that would provide broader language to work with all relevant stakeholders to clear the backlog for conversion from H1-B visas to permanent resident status. Your Reference Committee agrees with this language and accordingly recommends adoption of a substitute resolution in lieu of Resolution 229.

(31) RESOLUTION 230 – OPPOSITION TO FUNDING CUTS FOR PROGRAMS THAT IMPACT THE HEALTH OF POPULATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends Resolution 230 be amended by addition to read as follows:

RESOLVED, That our American Medical Association actively advocate that Congress, the White House, and senior cabinet officials ensure that programs designed to meet daily needs, support changes in individual behavior, and improve the health of populations remain funded at least at current levels and remain available without additional restrictions or rules. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Resolution 230 be adopted as amended.

Resolution 230 asks that our American Medical Association actively advocate that Congress, the White House, and senior cabinet officials ensure that programs designed to meet daily needs, support changes in individual behavior, and improve the health of populations remain funded at current levels and remain available without additional restrictions or rules. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 230. Testimony was presented that “Healthy People 2020” highlights the importance of addressing the social determinants of health by including the creation of social and physical environments that promote good health for all. Testimony was also presented that our AMA adopted Policy H-295.874 supporting educating medical students in the social determinants of health (SDOH) and cultural competence, and that our AMA has policy opposing policies and rules that would lead to barriers to access resources that are examples of SDOH. Your Reference Committee further heard that the Administration is proposing funding cuts to the Supplemental Nutrition Assistance Program, education programs, housing subsidies and community development block grants, and other programs. An amendment was

offered to clarify that our AMA advocate for at least maintaining the current funding levels. Having heard support for this amendment, your Reference Committee recommends that Resolution 230 be adopted as amended.

(32) RESOLUTION 231 – ONLINE CONTROLLED DRUGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 231 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support efforts that ~~advocate for changes to applicable laws and regulations to~~ help the Drug Enforcement Administration and the Food and Drug Administration to better regulate and control the illegal online sales and distributions of drugs, dietary supplements, and herbal remedies ~~controlled substances that lack a valid prescription~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 231 be adopted as amended.

Resolution 231 asks that our American Medical Association advocate for changes to applicable laws and regulations to help the Drug Enforcement Administration and the Food and Drug Administration to better regulate and control the online sales and distribution of controlled substances that lack a valid prescription. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 231. Your Reference Committee heard testimony that indicated that existing laws may not be adequate to cover the current landscape of drugs. Testimony was also presented that there are many products being sold online that fall into a gray area of not being FDA-approved and not being scheduled by the DEA. Your Reference Committee heard testimony to amend Resolution 231 to address these concerns to better clarify the intent. Accordingly, your Reference Committee recommends adopting Resolution 231 as amended.

(33) RESOLUTION 236 – REDUCING MIPS REPORTING BURDEN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 236 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with ~~the Medicare Payment Advisory Commission (MedPAC)~~ the Centers for Medicare and Medicaid Services (CMS) to advocate for ~~a new replacement voluntary reporting system that has~~ improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians (Directive to Take Action); and be it further

RESOLVED, That, in the interim, our AMA work with CMS to shorten the yearly ~~Merit-Based Incentive Payment System (~~MIPS~~)~~ data reporting period from one-year to ~~any~~ a minimum of 90-days (of the physician's choosing) ~~interval~~ within the calendar year~~(of the physician's choosing)~~. (Directive to Take Action)

RECOMMENDATION B:

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

Resolution 236 asks that our American Medical Association work with the Medicare Payment Advisory Commission and the Centers for Medicare and Medicaid Services (CMS) to advocate for a new replacement voluntary reporting system that has significant input from practicing physicians and reduces regulatory and paperwork burdens on physicians (Directive to Take Action); and be it further, that, in the interim, our AMA work with CMS to shorten the yearly Merit-Based Incentive Payment System data reporting period from one-year to any 90-day interval within the calendar year (of the physician's choosing). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 236. Your Reference Committee heard that most testimony supported the goals of the resolves. Your Reference Committee heard that our AMA has been able to make significant improvements to the MIPS program since its implementation, and is continuing to aggregate physician and specialty society input to improve the MIPS program and reduce the regulatory reporting burden for physicians. Your Reference Committee also heard that our AMA is working with the Centers for Medicare and Medicaid Services (CMS), not MedPAC, to refine and improve the MIPS program. In addition, your Reference Committee heard testimony in support of improving the MIPS program, as opposed to designing a new program. There was also supportive testimony regarding

the second resolve; however your Reference Committee heard testimony that the language should be clarified to specify that our AMA work with CMS to shorten the MIPS reporting period to a minimum of 90 days. Your Reference Committee heard testimony seeking support to refer the first Resolve for further study. Your Reference Committee, however, believes that the weight of the testimony favors adoption of Resolution 236 with an amendment.

(34) RESOLUTION 241 – ACCURACY AND ACCOUNTABILITY OF PHYSICIAN COMPENSATION REPORTING BY DRUG AND DEVICE COMPANIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 241 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~adopt~~ advocate ~~as policy~~ that (1) any payment or transfer of value ~~compensation~~ reported as part of the Physician Payments Sunshine Act should include whether ~~be accompanied by a verifiable receipt signed by~~ the physician acknowledged ~~ing~~ receipt of said payment or transfer of value and (2) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that a contested reported ~~compensation~~ payment or transfer of value should be removed immediately from the Open Payments~~Data.CMS.gov~~ website until the reporting company validates the compensation with verifiable documentation ~~a signed receipt~~ (New HOD Policy).~~; and be it further~~

~~RESOLVED, That our AMA advocate that companies reporting physician payments under the Physician Payments Sunshine Act without proper documentation shall be fined $1,000 per occurrence. (New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 241 be adopted as amended.

Resolution 241 asks that our American Medical Association adopt as policy that any compensation reported as part of the Physician Payments Sunshine Act should be accompanied by a verifiable receipt signed by the physician acknowledging receipt of said compensation (New HOD Policy); and be it further, that our AMA advocate that

contested reported compensation should be removed immediately from the OpenPaymentsData.CMS.gov website until the reporting company validates the compensation with a signed receipt (New HOD Policy); and be it further, that our AMA advocate that companies reporting physician payments under the Physician Payments Sunshine Act without proper documentation shall be fined $1,000 per occurrences. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 241. Your Reference Committee heard testimony that certain drug and device manufacturers are inappropriately reporting payments to the Open Payments website for food, beverages, and other gifts that were never received, not wanted, or inappropriately reported. Your Reference Committee also heard testimony that requiring physician verification of receipt of over $8 billion in annual payments and over 10 million records may be impractical and cause unnecessary administrative burden on physicians. Your Reference Committee also heard that the Centers for Medicare and Medicaid Services has the authority (1) to collect additional information and context from drug and device manufacturers including physician verification and (2) to fine drug and device manufacturers for inaccurate reporting. Accordingly, your Reference Committee recommends adoption of Resolution 241 with amendment.

(35) RESOLUTION 242 – PHARMACY BENEFIT MANAGERS AND COMPOUNDED MEDICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 242 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association amend Policy H-125.986 by addition as follows:

Pharmaceutical Benefits Management Companies H-125.986

Our AMA: (1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;

(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care; ~~and~~
(6) supports efforts ~~Congressional action~~ to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and
(7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (Modify Current HOD Policy)

RECOMMENDATION B:

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

Resolution 242 asks that our American Medical Association amend policy H-125.986 by addition as follows: Pharmaceutical Benefits Management Companies H-125.986. Our AMA: 1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates; (2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate; (3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies; (4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; (5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care; and (6) supports Congressional action to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications, and encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (Modify Current HOD Policy)

Your Reference Committee heard testimony concerning the role that pharmacy benefit management companies (PBMs) have played and continue to play. It became

increasingly clear from the testimony that there is a considerable amount of frustration and confusion about the role of PBMs. Your Reference Committee heard testimony that these entities that have such power over the prescriptions that our patients receive need, to have much greater transparency about their tactics and impact. Your Reference Committee also recognizes that our AMA already undertakes considerable advocacy to take PBMs out of the shadows, including the TruthinRx campaign as well as via multiple pieces of model state legislation and advocacy at the National Association of Insurance Commissioners. Your Reference Committee also heard testimony that supporting Congressional action as a specific directive may not be the most appropriate action and that our AMA should preserve flexibility for advocacy efforts. Accordingly, your Reference Committee recommends adopting Resolution 242 with amendment.

(36) RESOLUTION 243 – REPORT HEALTH CARE PROVIDER SEX CRIMES TO LAW ENFORCEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends adoption of the following resolution in lieu of Resolution 243:

ADDRESSING BARRIERS TO REPORTING HEALTH CARE PROVIDER SEX CRIMES

RESOLVED, that our American Medical Association support the efforts and work with the Federation of State Medical Boards to examine disciplinary data, barriers that delay or prevent reporting of sex crimes, and the cooperation of state medical boards with law enforcement in order to ensure a comprehensive approach to identifying and addressing sexual crimes within medicine. (New HOD Policy)

Resolution 243 asks that our American Medical Association work with the Federation of State Medical Boards to create and encourage state adoption of “model public health code language” that would require all state medical boards to report criminal sexual conduct or predatory sexual behavior to appropriate law enforcement authorities. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony that recent sexual assault scandals have demonstrated that physicians must do more to protect patients from sexual predators in our ranks. As physicians, we have an ethical obligation to report to appropriate authorities behavior that impacts patient health and safety. As Resolution 243 makes clear, the current system has failed patients and changes must be made.

Resolution 243 is intended to fill gaps in the system that allows sexual abusers to go undetected, and your Reference Committee commends the Michigan delegation for taking on this urgent issue. However, your Reference Committee heard testimony suggesting that, while well-intended, our AMA can do more to ensure timely reporting of health care provider sex crimes to law enforcement. Resolution 243 would require

medical boards to report criminal sexual conduct or predatory sexual behavior to law enforcement. But, in fact, testimony stressed that state medical boards cooperate with law enforcement in investigations when an incident may be a criminal violation in addition to unprofessional conduct under each state's medical practice act. Testimony also stressed that, as recent incidents of egregious violations have demonstrated, often reports are not made to the state medical board of jurisdiction. As such, testimony suggested that adoption of this resolution in its current form will create merely the illusion of action by this body, but will do little to change the current system that has fallen short. Your Reference Committee agrees with those urging a more comprehensive approach.

Testimony from the Federation of State Medical Boards (FSMB) informed the Reference Committee that a Workgroup on Sexual Boundary Violations will soon convene to identify, evaluate and recommend best practices for reporting violations to state medical boards and law enforcement; address barriers to reporting incidents of sexual misconduct and identify best practices, including investigation, referral, and public outreach; collect and review available disciplinary data, including incidence and spectrum of severity of behavior and sanction, related to sexual boundary violations; evaluate the impact of state medical board public outreach on reporting; review the FSMB's 2006 policy, Addressing Sexual Boundaries: Guidelines for State Medical Boards; and assess the prevalence of sexual boundary/harassment training in medical schools and graduate medical education and develop recommendations and/or resources to address gaps. That FSMB working group will identify and make recommendations for policy changes so that abusive behavior and misconduct can be detected earlier and stopped.

Your Reference Committee agrees with those who recommended that our AMA participate in FSMB's process and that the workgroup findings inform our AMA's future policy making. Your Reference Committee agrees that this support from our AMA honors the spirit and goals of Resolution 243, while offering a more comprehensive and impactful approach.

Therefore, your Reference Committee recommends that a substitute resolution be adopted in lieu of Resolution 243 to state that our AMA will support the efforts of and work with the Federation of State Medical Boards to examine disciplinary data, barriers that delay or prevent reporting of sex crimes, and the cooperation of state medical boards with law enforcement in order to ensure a comprehensive approach to identifying and addressing sexual crimes within medicine.

(37) RESOLUTION 244 – INCREASING THE LEGAL AGE OF PURCHASING AMMUNITION AND FIREARMS FROM 18 TO 21
RESOLUTION 248 – OPPOSITION TO FIREARM CONCEALED CARRY RECIPROCITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-145.985 be amended by addition and deletion to read as follows:

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of ~~18~~ 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d~~c~~) the imposition of significant licensing fees for firearms dealers;
(e~~d~~) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f~~e~~) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies

to evaluate and support local efforts to enact useful controls. (Modify Current HOD Policy)

(4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-145.985 be adopted as amended in lieu of Resolutions 244 and 248.

Resolution 244 asks that our American Medical Association amend policy H-145.985, "Ban on Handguns and Automatic Repeating Weapons," by addition and deletion to read as follows: It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to: (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers; (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of ~~18~~21 and bans of purchases of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21. (c) the imposition of significant licensing fees for firearms dealers; (d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and (e) mandatory destruction of any weapons obtained in local buy-back programs. (2) Support legislation outlawing the Black Talon and other similarly constructed bullets. (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls. (Modify Current HOD Policy) Resolution 248 asks that our American Medical Association, in the interest of safety for all citizens, vigorously oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that 36 have stricter laws. (New HOD Policy)

Your Reference Committee heard extensive testimony on Resolutions 244 and 248. Your Reference Committee heard testimony that our AMA has urged Congress to take immediate action on common sense solutions to reduce the epidemic of gun violence in America. Our AMA believes that gun violence in America is a public health crisis that needs comprehensive, multi-faceted public health solutions. As physicians, our AMA sees first-hand the devastating consequences of gun violence to victims and their

families and friends. Accordingly, your Reference Committee recommends amending Policy H-145.985 to incorporate Resolutions 244 and 248 with amendments.

While your Reference Committee heard testimony in opposition to Resolution 244, your Reference Committee heard testimony in favor of increasing the legal age of purchasing ammunition and firearms from 18 to 21. Testimony was heard that while current federal law limits the purchase of handguns to age 21 and purchase of long guns to age 18 from a licensed firearms dealer, unlicensed persons may sell a long gun to a person of any age and handguns to individuals 18 and older; and federal law and laws in 38 states allow 18 to 20 year olds to legally possess handguns from unlicensed sellers, such as online retailers and sellers at gun shows. Your Reference Committee also heard testimony expressing concerns about the ability of certain categories of individuals being able to purchase or possessing firearms, such as, 18 to 20 year olds who are law enforcement and military personnel. This testimony also recommended amending Resolution 244 to add these categories. Accordingly, your Reference Committee recommends that Resolution 244 be amended to include these categories.

Your Reference Committee heard strong testimony in favor of adoption of Resolution 248. Testimony was presented that federal legislation to permit "concealed carry reciprocity" across state lines would lower standards across the country to the lowest common denominator by requiring all states to recognize concealed carry permits granted by other states and by allowing citizens with concealed carry permits in one state to carry guns into states that have stricter laws. Your Reference Committee also heard testimony that Attorneys General from 16 states and the District of Columbia, the National Law Enforcement Partnership to Prevent Gun Violence made up of 9 national law enforcement organizations, and the International Association of Chiefs of Police have opposed "concealed carry reciprocity" because of the danger it poses to law enforcement agents, to victims of domestic violence, and to the public. Your Reference Committee believes Resolution 248 would appropriately fill a gap in existing AMA policy, and accordingly, recommends adoption of the language of Resolution 248 by incorporating the language into Policy H-145.985.

(38) RESOLUTION 245 – OPPOSING NCOIL ATTEMPTS TO STOP PHYSICIAN DISPENSING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-120.990 be <u>amended by addition</u> to read as follows.

Physician Dispensing H-120.990
Our AMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines.

<u>Our AMA oppose legislative and other efforts that are in conflict with AMA policies concerning patient access to physician-dispensed drugs and devices.</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-120.990 be adopted as amended in lieu of Resolution 245.

Resolution 245 asks that our American Medical Association oppose the National Conference of Insurance Legislators "Workers' Compensation Pharmaceutical Reimbursement Rates Model Act." (New HOD Policy)

Your Reference Committee heard limited testimony on this resolution. Your Reference Committee notes that current policy provides guidance to our AMA to support a physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines (see Code of Medical Ethics 9.6.6 Prescribing & Dispensing Drugs & Devices). Your Reference Committee also agrees with the resolution's author that our AMA should actively oppose efforts that would conflict with this right, whether legislative, regulatory or in other venues. Accordingly, your Reference Committee recommends amending existing policy by addition in lieu of Resolution 245.

(39) RESOLUTION 246 – SUPPORT FOR PATIENTS AND PHYSICIANS IN DIRECT PRIMARY CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 246:

SUPPORT FOR PATIENTS AND PHYSICIANS IN DIRECT PRIMARY CARE

RESOLVED, That our AMA reaffirm Policy H-385.912, Direct Primary Care (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA support efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists. (New HOD Policy)

Resolution 246 asks that our American Medical Association advocate for changes in federal law to establish that Direct Primary Care membership fees may be paid with pre-tax funds (New HOD Policy); and be it further, that our AMA develop model legislation to establish the right of patients to seek care from specialists who are contracted with their insurance plan and to have that service covered when referred by a primary care physician who is not contracted with their insurance plan. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 246. Your Reference Committee also heard testimony that our AMA has already expressed its support for the Primary Care Enhancement Act (H.R. 365/S. 1358) in a letter dated January 27, 2017 to the House of Representatives sponsors of the legislation. Moreover, your Reference Committee heard testimony describing payer policies that prevent patients in Direct Primary Care practices from accessing specialty care, even when the specialist is in the patient's provider network. Moreover, your Reference Committee heard that many health insurers will not provide coverage for specialty care when the patient is referred to the specialist by a DPC physician.

Your Reference Committee believes that the DPC model will not remain viable if patients are unable to combine it with health insurance policies that cover specialty care or includes specialists. Your Reference Committee also heard testimony for supporting a substitute resolution in lieu of Resolution 246 that allows for our AMA to engage on various solutions to this issue, whether they be legislative, regulatory, or other, rather than developing a model bill as called for in Resolution 246. Accordingly, your Reference Committee recommends that a substitute resolution be adopted in lieu of Resolutions 234 and 246.

(40) RESOLUTION 247 – OPPOSED REPLACEMENT OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM WITH THE VOLUNTARY VALUE PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 247 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined (New HOD Policy); and be it further

RESOLVED, That our AMA study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program need<u>s</u> to be made (Directive to Take Action); and be it further

RESOLVED, That our AMA continue its advocacy efforts to improve the MIPS program, specifically requesting:
1. True EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures,
2. Safe harbor protections for entities providing clinical data for use in the MIPS program,
3. Continued infrastructure support for smaller practices that find participation particularly burdensome,

4. ~~Support for risk adjustment of geographic populations for outcome measures~~ Adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation, and
5. Limiting public reporting of physician performance to those measures used for scoring in the MIPS program; and be it further

RESOLVED, That our AMA determine if population measures are appropriate and fair for measuring physician performance (Directive to Take Action); and be it further

~~RESOLVED, That our AMA, if possible, develop criteria under which appropriate and fair population measures might be considered for measurement of physician performance. (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 247 be adopted as amended.

Resolution 247 asks that our American Medical Association oppose the replacement of the Merit-1 Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently 2 defined (New HOD Policy); and be it further, that our AMA study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program need to be made (Directive to Take Action); and be it further, that our AMA continue its advocacy efforts to improve the MIPS program, specifically requesting: 1.True EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures, 2. Safe harbor protections for entities providing clinical data for use in the MIPS program, 3. Continued infrastructure support for smaller practices that find participation particularly burdensome, 4. Support for risk adjustment of geographic populations for outcome measures, and 5. Limiting public reporting of physician performance to those measures used for scoring in the MIPS program (New HOD Policy); and be it further, that our AMA determine if population measures are appropriate and fair for measuring physician performance (Directive to Take Action); and be it further, that our AMA, if possible, develop criteria under which appropriate and fair population measures might be considered for measurement of physician performance. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 247. Your Reference Committee heard testimony that was supportive of the intent of Resolution 247 to oppose the Voluntary Value Program, and to ask our AMA to continue to advocate to improve the Merit-based Incentive Payment System (MIPS) program to ensure electronic health record data transparency, safe harbor protections for entities providing clinical data, and limited use of public reporting of physician performed to measures used for scoring in the MIPS program. However, your Reference Committee also heard testimony that the final Resolve should be removed, as the fourth Resolve

which asks our AMA to determine if population measures are appropriate and fair for measuring physician performance is sufficient at this time. Moreover, your Reference Committee also heard that the fourth point of the fourth Resolve should be broadened. Therefore, your Reference Committee recommends adoption of Resolution 247 as amended.

(41) RESOLUTION 250 – CLARIFICATION OF GUIDELINES FOR ONLINE PRESCRIBERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 250 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when a valid ~~an appropriate~~ patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 250 be adopted as amended.

Resolution 250 asks that our American Medical Association support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when an appropriate patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care. (New HOD Policy)

Your Reference Committee heard limited testimony on Resolution 250. Your Reference Committee heard testimony that as telemedicine and e-prescribing of controlled substances continue to evolve, so must our AMA policy to support continuity of care and new ways of ensuring patients' access to care. Your Reference Committee also heard testimony that this resolution highlights the need to further augment our AMA policy with respect to e-prescribing of medications, including controlled substances—but do it in such a way as to build on our policy with the appropriate balance for recognizing evolving modes of care with ensuring a valid patient-physician relationship exists. Your Reference Committee also heard testimony that a technical edit should be made to Resolution 250 to match existing policy regarding a valid patient-physician relationship. Accordingly, your Reference Committee recommends adoption of Resolution 250 as amended.

(42) RESOLUTION 251 – SCOPE OF PRACTICE EXPANSION ADVOCACY & IMPACTS ON PHYSICIANS & MEDICAL STUDENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Fourth Resolve of Resolution 251 be amended by addition and deletion to read as follows:

RESOLVED, that the AMA study the impact of scope of practice expansion on medical student choice of specialty~~decisions to enter into primary care~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 251 be adopted as amended.

Resolution 251 asks (1) that our American Medical Association (AMA) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience (Directive to Take Action); and be it further; (2) that the AMA advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability (New HOD Policy); and be it further; (3) that the AMA advocate for the inclusion of scope of practice expansion into measurements of physician well-being; (New HOD Policy) and be it further; (4) that the AMA study the impact of scope of practice expansion on medical student decisions to enter into primary care (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 251. Your Reference Committee heard testimony that through resources, research, and the Scope of Practice Partnership, our AMA has what physicians need to advance your scope of practice advocacy agenda. Your Reference Committee also heard testimony that state policy makers face increasing pressure to expand the scope of practice of non-physician practitioners as a means to address the physician workforce shortages. Your Reference Committee agrees with testimony that scope of practice expansions likely have an impact on medical students' decision of whether to pursue a career in primary care, but that scope of practice expansions can also potentially influence a medical student's decision to pursue certain specialty care. Your Reference Committee believes that a comprehensive report that broadly examines the impact of scope of practice on medical students' choice of specialty would be informative and a welcome addition to your AMA's scope of practice arsenal. Accordingly, your Reference Committee recommends adoption of Resolution 251 as amended.

(43) RESOLUTION 254 – OPPOSITION TO REGULATIONS THAT PENALIZE IMMIGRANTS FOR ACCESSING HEALTH CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 254 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA, upon the release of ~~and~~ a proposed rule, ~~or~~ regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition, and be it further

RESOLVED, That our AMA amend AMA Policy H-20.901 by addition and deletion to read as follows:
Our AMA: ~~(1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC;~~ (1~~2~~) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2~~3~~) recommends that non- immigrant travel into the United States not be restricted because of HIV status; and (3~~4~~) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 254 be adopted as amended.

Resolution 254 asks AMA, upon the release of a~~nd~~ proposed rule or regulation~~s~~ that would deter immigrants and/or their dependents from utilizing non-cash public benefits including Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and be it further, that our AMA amend AMA policy H-20.901 by addition and deletion to read as follows: Our AMA (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United

States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

Your Reference Committee heard supportive testimony on Resolution 254. Your Reference Committee heard that under existing AMA policy, the AMA supports the public charge provision of the Immigration Reform Act of 1990 (PL 101-649), but that when our AMA adopted that policy the federal government was seeking to address those individuals coming into the United States with communicable diseases. Now the administration is seeking to expand the public charge definition to include non-cash public benefits such as Medicaid, the Children's Health Insurance Program, and food stamps. Your Reference Committee heard that existing AMA policy should be amended to address these potential changes to the definition of public charge that will significantly impact the ability of families seeking a green card to receive medical services from Medicaid, the Children's Health Insurance Program, and other critical programs. Accordingly, your Reference Committee recommends that Resolution 254 be adopted as amended.

(44) RESOLUTION 255 – 340B DRUG DISCOUNT PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first, second, and fourth Resolves of Resolution 255 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 255 be referred for report back at the 2018 Interim Meeting of the House of Delegates.

Resolution 255 asks (1) that our American Medical Association advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes (New HOD Policy); (2) that our AMA support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight (New HOD Policy); (3) that our AMA support discontinuing the use of the Disproportionate Share Hospital adjustment as a determining measure for 340B program eligibility (New HOD Policy); and be it further (4) that our AMA recognize the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients. (New HOD Policy).

Your Reference Committee heard generally supportive testimony on Resolution 255. Your Reference Committee heard testimony that there should be more transparency in the 340B programs and low income patients should benefit from this rebate. The

Committee also heard testimony that the federal agency responsible for administering the program needs more resources and oversight authority and that physician practices that provide a commensurate amount of care to low income and indigent patients comparable to federal qualified health centers and other safety net programs should also be eligible for the 340B discount. The Reference Committee, however, heard testimony that additional research and analysis is needed to assess how to address those DSH hospitals that should not benefit from 340B rebates and those that should benefit. Therefore, your Reference Committee recommends adopting Resolves 1, 2, and 4, and referral of Resolve 3 of Resolution 255 with report back at Interim 2018.

(45) RESOLUTION 256 – FEDERAL AVIATION ADMINISTRATION BASICMED EXAMS TO BE DONE BY PHYSICIANS WITH PRESCRIPTIVE AUTHORITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends the following resolution be adopted in lieu of Resolution 256:

DEFINING PHYSICIAN FOR THE FEDERAL AVIATION ADMINISTRATION, THE DEPARTMENT OF TRANSPORTATION, AND CONGRESS

RESOLVED, That our American Medical Association advocate for the Federal Aviation Administration, the Department of Transportation, and Congress to define a "physician" as an individual possessing degree of either a Doctor of Medicine or Doctor of Osteopathic Medicine. (New HOD Policy)

Resolution 256 asks that our American Medical Association advocate for the Federal Aviation Administration to restrict BasicMed examinations for pilots to physicians with prescriptive authority (Directive to Take Action); and be it further that AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," be amended by addition to read as follows: Practicing Medicine by Non-Physicians H-160.949 Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician

clinical staff in all areas of medicine; and (6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.; and (7) opposes efforts by federal agencies (i.e., the Federal Aviation Administration and the Department of Transportation) to permit non-prescribing physicians to conduct medical examinations required to obtain special transportation licenses. (Modify Current HOD Policy).

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 256. Your Reference Committee heard testimony that the Federal Aviation Administration and the Department of Transportation are interpreting the term "physician" to include individuals who are not doctors of medicine or osteopathy. Your Reference Committee also heard that this interpretation goes against well-establish AMA policy. Your Reference Committee further heard testimony that Resolution 256 should be amended to complement existing AMA policy and to not introduce the term "physician non-prescribers," which may cause confusion in interpreting current policy. Testimony also supported expanding the scope of Resolution 256 to include Congress. Accordingly, your Reference Committee recommends that a substitute resolution be adopted in lieu of Resolution 256.

(46) RESOLUTION 217 – REFORMING THE ORPHAN DRUG ACT
RESOLUTION 227 – AN OPTIONAL NATIONAL PRESCRIPTION DRUG FORMULARY
RESOLUTION 238 – REFORM OF PHARMACEUTICAL PRICING: NEGOTIATED PAYMENT SCHEDULES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 217, 227, and 238 be referred.

Resolution 217 asks that our American Medical Association support efforts to reform the Orphan Drug Act by closing loopholes identified by the Food and Drug Administration in order to protect the Act's original intent of promoting therapies targeting rare diseases (New HOD Policy); and be it further, that our AMA support increased transparency in development costs, post-20 approval regulation and overall earnings for pharmaceuticals designated as "Orphan Drugs" (New HOD Policy); and be it further, that our AMA support modifications to the exclusivity period of "Orphan Drugs" to increase access to these pharmaceutical drugs for patients with rare diseases. (New HOD Policy) Resolution 227 asks that our American Medical Association develop a set of principles for a National Prescription Drug Formulary (NPD Formulary) that are designed to lower prescription drug prices to the patient, and be transparent, independent, non-profit, and fee-based, with a report back to the AMA HOD at the 2018 Interim Meeting (Directive to Take Action); and be it further, that our AMA produce model legislation for an NPD Formulary with input from appropriate stakeholders based on a set of principles for such a Formulary that the AMA will develop, and that our AMA join with appropriate stakeholders to advocate that Congress authorize the establishment of this NPD Formulary that will be available to all Americans as an option to their healthcare

insurance program in an actuarially appropriate manner. (Directive to Take Action) Resolution 238 asks that our American Medical Association support federal legislation that modifies the Hatch-Waxman Act and the Biologics Price Competition and Innovation Act (Biosimilars Act) to institute the replacement of time-specific patent protections with negotiated payment schedules and indefinite exclusivity for U.S. Food and Drug Administration-approved drugs in the Medicare Part D Program. (New HOD Policy)

Your Reference Committee heard varying testimony on Resolutions 217, 228, and 238. Your Reference Committee strongly supports advocacy and initiatives that will reduce the cost of prescription drugs and expand access. Your Reference Committee heard testimony that the AMA is currently advocating for measures to increase market competition as well as greater transparency of cost price along the pharmaceutical supply chain.

Your Reference Committee heard testimony on Resolution 217 that incentives are needed to support innovation in drug development for rare diseases and generally supports the intention of the Orphan Drug Act. Your Reference Committee also heard testimony that congressional concerns with and public reports on drug developers' potential manipulation of the ODA incentives are not consistent with the original intent of ODA and may be driving higher drug costs and increased sales. Your Reference Committee also heard testimony that this area of law is highly complex and complicated and that our AMA should work with the FDA to further study this report.

Your Reference Committee heard testimony on Resolution 227 that a national formulary would not promote innovation and competition and could substantially limit patient access to medically necessary options. Your Reference Committee heard testimony on Resolution 238 that modifying various provisions of the Food, Drug, and Cosmetic Act as well as other federal laws such as the Social Security Act and the U.S. Patent Act in order to institute the replacement of time-specific patent protections with negotiated payment schedules and indefinite exclusivity for FDA-approved drugs in the Medicare Part D Program could limit patient access to clinically necessary alternative options and depress innovation while interjecting significant confusion and complexity in the patent system and the FDA regulatory regime.

All three resolutions are either a potentially complex solution to, or contain novel suggestions to address, the high cost of prescription drugs. Given these concerns, your Reference Committee recommends that Resolutions 217, 227, and 238 be referred.

(47) RESOLUTION 226 – MODEL STATE LEGISLATION FOR ROUTINE PREVENTATIVE PROSTATE CANCER SCREENING FOR MEN AGES 55-69

RECOMMENDATION:

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

Resolution 226 asks that our American Medical Association develop model state legislation for screening of asymptomatic men ages 55-69 for prostate cancer after

informed discussion between patients and their physician without annual deductible or co-pay. (Directive to Take Action)

Your Reference Committee heard mixed testimony about Resolution 226. Your Reference Committee heard testimony about the importance of shared decision-making between patients and their physicians about the benefits and risks associated with screening for prostate cancer in asymptomatic men. Your Reference Committee also heard testimony identifying other preventive services that are covered without annual deductible or co-pay. Your Reference Committee notes that the US Preventive Services Task Force recently gave PSA-based screening a C grade, recommending selectively offering or providing screening to asymptomatic men aged 55–69 based on professional judgment and patient preferences. Testimony was supportive of coverage for patients who, in consultation with their physicians, understand the risks and decide to undergo screening. Testimony also stated that the Council on Medical Services (CMS) and Council on Science and Public Health (CSAPH) are working on a joint report for the Interim Meeting in 2018 that addresses value-based insurance design for preventative interventions. Your Reference Committee believes that further study into first dollar coverage is necessary before model legislation should be considered and that our AMA should not adopt policy prior to the CMS and CSAPH joint report is issued. Accordingly, your Reference Committee recommends that Resolution 226 be referred.

(48) RESOLUTION 235 – HOSPITAL CONSOLIDATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 235 be referred.

Resolution 235 asks that our American Medical Association actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets (New HOD Policy); and be it further, that our AMA study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist. (Directive to Take Action)

Your Reference Committee heard testimony expressing concern about the negative impact that hospital mergers in already highly concentrated hospital markets are having on competition, the practice of medicine and patient care. Your Reference Committee heard testimony calling for our AMA to challenge any further hospital mergers in such markets. However, testimony also pointed out that many hospital mergers in highly concentrated markets are announced every year, sometimes involve multiple hospitals, and that each such merger raises complex economic and antitrust issues that require careful and complete analysis. Your Reference Committee acknowledges that our AMA does not have the resources to perform the extensive economic and antitrust analyses necessary to oppose each and every one of these mergers. Finally, while some testified in favor or studying the benefits and risks of hospital rate setting, some expressed concern that adoption of the second resolve might place our AMA in an awkward advocacy position if adoption were perceived as our AMA's favoring rate regulation for hospitals but having an special exemptions for physicians. Accordingly, due to the complexity of the issues raised in testimony related to both resolves, your Reference Committee recommends that Resolution 235 be referred.

(49) RESOLUTION 252 – REPEAL OF GROUP PURCHASING ORGANIZATIONS AND PHARMACY BENEFIT MANAGERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 252 be referred.

Resolution 252 asks that our AMA educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages (Directive to Take Action); and be it further that our AMA reaffirm Policy H-100.956, which states in part that "Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs." (Reaffirm HOD Policy).

Your Reference Committee heard mixed testimony on Resolution 252. Your Reference Committee heard testimony that in 2016, a similar resolution was brought and referred for decision. The Board of Trustees decided to not adopt the resolution. Testimony furthered indicated that there is little empirical evidence to definitively assess the impact of the vendor-fee-based funding structure protected under the anti-kickback safe harbor. Your Reference Committee heard testimony that repealing the GPO safe harbor will impact the entire health care system and could negatively impact access to needed supplies to our patients. Furthermore, your Reference Committee heard testimony that Resolution 252 may also contradict AMA policy to pursue a collaborative and evidence-based approach, and it may not effectively address the underlying issue, while simultaneously producing unintended consequences. Accordingly, given these concerns, your Reference Committee recommends that Resolution 252 be referred.

(50) RESOLUTION 219 – IMPROVING MEDICARE PATIENTS' ACCESS TO KIDNEY TRANSPLANTATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 219 be referred for decision.

Resolution 219 asks that our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further, that our AMA actively oppose the "Dialysis PATIENTS Demonstration Act of 19 2017" (S. 2065) (HR 4143) (Directive to Take Action); and be it further, that the House of Delegates receive a report back at the 2018 Interim Meeting regarding our AMA actions in opposing the PATIENTS Act (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 219. Your Reference Committee heard testimony from members whose specialty societies have publicly supported and opposed the specific piece of legislation that is the subject of Resolution 219. According to the testimony, there appears to be potential benefits and drawbacks to

this legislation that need further deliberation. Accordingly, your Reference Committee recommends that Resolution 219 be referred for decision.

(51) RESOLUTION 212 – VALUE-BASED PAYMENT SYSTEM

RECOMMENDATION:

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

Resolution 212 asks that our American Medical Association work to repeal the law that conditions a portion of a physician's Medicare payment on compliance with the Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs (Directive to Take Action); and be it further, that our AMA continue advocating for a reduction in the administrative burdens of compliance with value-based programs and that these programs comply with evidence-based standards. (Directive to Take Action)

Your Reference Committee heard mostly negative testimony on Resolution 212. Your Reference Committee heard testimony that it is too soon to repeal the Quality Payment Programs, as the program just began in 2017. Your Reference Committee agrees that our AMA should continue to work with the Centers for Medicare and Medicaid Services (CMS) to improve the Merit-based Incentive Payment System (MIPS) program and create additional Alternative Payment Models (APM) opportunities for physicians. Your Reference Committee also heard testimony that our AMA was successful, through the Bipartisan Budget Act of 2018, in including five key MACRA improvements that will allow CMS and physicians three additional years to gradually transition into the MIPS program. Moreover, your Reference Committee heard testimony that our AMA is already engaging in continuous advocacy efforts to improve the program for physicians. Accordingly, your Reference Committee recommends that Resolution 212 not be adopted.

(52) RESOLUTION 249 – SUPPORT ANY WILLING PROVIDER LEGISLATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 249 not be adopted.

Resolution 249 asks that our American Medical Association draft and promote model state legislation which: 1. Allows any patient covered by a specific managed care organization to choose to receive medical care from a physician (MD and DO) licensed in that state willing to agree to the terms of that managed care organization's contract, and 2. Allows a physician (MD or DO) licensed in that state willing to agree to the terms of a specific managed care organization's contract to participate in delivering medical services to the patients covered by that managed care organization without being mandated to accept any specific type of insurance or managed care organizations contract. (Directive to Take Action)

Your Reference Committee heard testimony against adoption of Resolution 249. Testimony described concerns with physicians being removed from networks and narrow networks. However, current AMA policy acknowledges that health plans or networks may develop and use criteria to determine the number, geographic distribution, and specialties of physicians needed. Therefore, your Reference Committee heard testimony that the model legislation in Resolution 249 would direct our AMA to develop would likely be in conflict with existing policy. However, in response to many of the concerns your Reference Committee heard regarding networks, our AMA has already developed model legislation requiring transparent and fair processes when physicians are removed from a network or not credentialed by a payer. Our AMA also has model legislation addressing network adequacy and ensuring that patients have access to in-network care. Finally, your Reference Committee heard testimony that our AMA has model legislation that prevents all products clauses from being included in physician contracts that covers the second resolve of this resolution. Accordingly, for the above reasons, your Reference Committee recommends that Resolution 249 not be adopted.

(53) BOARD OF TRUSTEES REPORT 21 – OWNERSHIP OF PATIENT DATA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 21 be filed.

Your Reference Committee heard limited testimony to Board of Trustees Report 21. Your Reference Committee heard testimony that the report provides an overview of the current laws and regulations at the state and federal levels that address ownership, access and use of patient data including under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations. It also looks at controls and processes in place to address physician and healthcare industry access and use of patient information. Your Reference Committee heard testimony to add a recommendation to Board Report 21 to have our AMA develop model state legislation concerning the ownership of patient data. Your Reference Committee believes that our AMA has taken a leadership role in ensuring appropriate use and access of these data by (1) working with ONC and HHS to encourage operational implementation of provisions in the 21st Century Cures Act to prohibit EHR vendors from blocking access to data and limiting a physician's ability to effectively utilize their EHR system; (2) providing physicians and practices with resources on negotiating employment and independent contractor agreements to assist in clarifying ownership of and access to patient information upon termination of employment or contracting; (3) supplying physicians and practices with educational tools about favorable EHR vendor contract terms covering ownership of, access to, and use of patient information; (4) educating physicians and practices on how to file a HIPAA complaint with the OCR; and (5) providing the Federation of Medicine with model legislation that ensures appropriate handling and access to patient data. Accordingly, your Reference Committee does not believe that a model state legislation is appropriate and recommends that Board of Trustees Report 21 be filed.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Edward P. Balaban, DO, Erin Harnish, MD, Mark Kogan, MD, William Monnig, MD, Gary Pushkin, MD, Luis Seija, and all those who testified before the Committee.

Edward P. Balaban, DO
American Society of Clinical Oncology

William Monnig, MD (Alternate)
Kentucky

Erin Harnish, MD
Washington

Gary Pushkin, MD (Alternate)
Maryland

Mark Kogan, MD (Alternate)
California

Luis Seija
Texas (Regional Medical Student)

R. Dale Blasier, MD, FRCS(C), MBA
North American Spin Society
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee C

Sherri S. Baker, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification
2. Council on Medical Education Report 4 – Evaluation of Clinical Documentation Training
3. Resolution 319 – All Payer Graduate Medical Education Funding
4. Resolution 320 - Young Physician Involvement in Maintenance of Certification

RECOMMENDED FOR ADOPTION AS AMENDED

5. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2008 House Policies
6. Council on Medical Education Report 3 – Expanding UME Without Concurrent GME Expansion
7. Council on Medical Education Report 6 – Mental Health Disclosures on Physician Licensing Applications
8. Resolution 301 – Protecting Medical Trainees from Hazardous Exposure
9. Resolution 302 – For-Profit Medical Schools or Colleges
10. Resolution 303 – Fellowship Start Date
11. Resolution 304 – Persons With Intellectual and Developmental Disabilities Designated as a Medically Underserved Population
12. Resolution 306 – Sex and Gender Based Medicine
13. Resolution 311 – Opioid Education for New Trainees
14. Resolution 312 – Suicide Awareness Training
15. Resolution 313 – Financial Literacy for Medical Students and Residents
16. Resolution 315 – Peer-Facilitated Intergroup Dialogue
17. Resolution 318 – AMA Convene Stakeholders to Transition USMLE to Pass / Fail Scoring

RECOMMENDED FOR REFERRAL

18. Resolution 305 – Standardization of Medical Licensing Time Limits Across States
19. Resolution 307 – Healthcare Finance in the Medical School Curriculum
20. Resolution 314 – Board Certification Changes Impact Access to Addiction Medicine Specialists
21. Resolution 316 – End "Part 4 Improvement in Medical Practice" Requirement for ABMS MOC®
22. Resolution 317 – Emerging Technologies (Robotics and AI) in Medical School Education

RECOMMENDED FOR NOT ADOPTION

23. Resolution 309 – Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency

Note: The following items were withdrawn and not considered.

Resolution 308 – Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency

Resolution 310 – U.S. Institutions With Restricted Medical License

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

RECOMMENDATION:

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

Council on Medical Education Report 2 asks 1) That our American Medical Association (AMA) continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so; and 2) That our AMA, through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.

Your Reference Committee heard testimony in support of the Council's comprehensive annual report to the HOD. During testimony, it was noted that the Council's efforts in working with the American Board of Medical Specialties and its member boards are improving the process for diplomates in many specialties by, for example, replacing the high-stakes examination with more relevant, less onerous, and cost efficient exams. The ABMS and the member boards have established a "Continuing Board Certification: Vision for the Future Commission" to modernize continuing board certification and engage physicians, the public, and key stakeholders in a collaborative process. The AMA, through the Council on Medical Education, continues to be actively engaged in following and contributing to the work of the Commission and, as noted in the report, the Council jointly convened a conference in March with the ABMS and the member boards to develop recommendations for the Commission. Although it was suggested that the recommendations in Resolution 318-A-17, "Oppose Direct to Consumer Advertising of the ABMS MOC Product," be further studied, your Reference Committee felt that CME Report 2 thoroughly explored and addressed this issue based on the testimony. Therefore, your Reference Committee recommends that Council on Medical Education Report 2 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 4 - EVALUATION OF CLINICAL DOCUMENTATION TRAINING

RECOMMENDATION:

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

Council on Medical Education Report 4 asks 1) That Policy D-295.314, "Study of Current Trends in Clinical Documentation," be rescinded, as having been fulfilled by this report; 2) That our American Medical Association (AMA) encourage medical schools and residency programs to design clinical documentation and electronic health records (EHR) training that provides evaluative feedback regarding the value and effectiveness of the training, and, where necessary, make modifications to improve the training; 3) That our AMA encourage medical schools and residency programs to provide clinical documentation and EHR training that can be evaluated and demonstrated as useful in clinical practice; and 4) That our AMA encourage medical schools and residency programs to provide EHR professional development resources for faculty to assure appropriate modeling of EHR use during physician/patient interactions.

Your Reference Committee heard unanimous support for this report's recommendations, which seek to address the need for medical school graduates to be fully prepared for clinical note taking in an electronic health record in order to improve patient care, reduce the risk of physician burnout, and ensure appropriate reimbursement. Testimony also praised the report for its acknowledgment that faculty likewise require training in this area, and for identifying specific training methods that have been proven to be effective. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted.

(3) RESOLUTION 319 – ALL PAYER GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 319 be <u>adopted</u>.

Resolution 319 asks that our AMA Board of Trustees investigate the status of implementation of AMA Policies D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs" and D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education" and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

Your Reference Committee heard almost unanimous support for Resolution 319. Testimony noted that this topic remains pressing for medical students and residents, and that this policy directive will ensure that a sense of urgency remains at the forefront of our AMA's advocacy efforts. Additional testimony elicited potential workforce considerations, which are of growing importance. It was observed that the AMA has extensive policy related to this issue (D-305.967), which already calls for reports to the HOD as changes to the GME financing system occur. Your Reference Committee concurs that this policy is relevant; therefore, additional calls for review of this important subject are timely and relevant. For these reasons, your Reference Committee recommends that Resolution 319 be adopted.

(4) RESOLUTION 320 - YOUNG PHYSICIAN INVOLVEMENT IN MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

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

Resolution 320 asks that our AMA submit commentary to the American Board of Medical Specialties (AMBS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards, and that our AMA work with American Board of Medical Specialties (AMBS) and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.

Your Reference Committee heard unanimous testimony in support of this resolution. The Council on Medical Education has begun discussions with the ABMS and its member boards to make them aware of the discrepancies that currently exist on the composition of the boards. At least two medical boards restrict participation until diplomates have had at least 10 years of certification or are of "mature age." The Council will also be addressing the 30-day or more time commitment to serve on member boards, and plans to investigate the current degree of young physician involvement/representation on the boards. Therefore, your Reference Committee recommends that Resolution 320 be adopted.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2008 HOUSE POLICIES

RECOMMENDATION A:

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

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of H-200.975, "Availability, Distribution and Need for Family Physicians," which should be retained, and H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs," which should be amended by addition and deletion, to read as follows:

H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs"

Our AMA: (1) recognizes the need for ~~(a)~~ appropriate mechanisms to include medical students and resident

physicians in the monitoring and advocacy services of state ~~existing medical society impaired~~ physician health programs~~;~~ and ~~(b) these~~ wellness and other programs ~~to include activities~~ to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services~~medical school impairment treatment programs and that schools ensure that these services are provided confidentially~~.

RECOMMENDATION B:

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

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

Your Reference Committee heard testimony that H-200.975, “Availability, Distribution and Need for Family Physicians,” should be retained, to avoid the removal from policy of the phrase "financing measures for medical education and research," which is important to primary care. In addition, testimony was heard that our AMA needs to have mechanisms in place to allow for state physician health programs to enroll non-licensed medical students and residents in their monitoring processes. Therefore, your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended.

(6) COUNCIL ON MEDICAL EDUCATION REPORT 3 - EXPANDING UME WITHOUT CONCURRENT GME EXPANSION

RECOMMENDATION A:

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

3) That our AMA ~~encourage~~ strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation. (Directive to Take Action)

RECOMMENDATION B:

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

Council on Medical Education Report 3 asks 1) That Policy D-305.967 (31), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," be rescinded, as having been fulfilled by this report; 2) That our American Medical Association (AMA) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; 3) That our AMA encourage legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates; and 4) That our AMA encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

Your Reference Committee heard both online and in-person testimony in strong support of Council on Medical Education Report 3. Speakers noted that increased competition for limited GME training slots could deter well-qualified applicants from entering training due to a fear of accruing substantial medical school debt without the guarantee of placement in the physician workforce. Testimony also supported the development of GME funding sources beyond Medicare, and noted the importance of enhanced data collection related to Match rates. All testimony was in near-agreement that this is an important topic that bears ongoing surveillance. An amendment was proposed to Recommendation 3, which strengthens the language related to our AMA's proposed advocacy work and considers the makeup of the U.S. physician workforce. Therefore, your Reference Committee recommends that the recommendations of Council on Medical Education Report 3 be adopted as amended.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 6 - MENTAL HEALTH DISCLOSURES ON PHYSICIAN LICENSING APPLICATIONS

RECOMMENDATION A:

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

1. That our American Medical Association (AMA) amend Policy H-275.970, Part 5, "Licensure Confidentiality," by addition and deletion to read as follows:

The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is ~~currently~~ suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

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

2. That our AMA encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards ~~American Psychiatric Association~~ that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)." (Directive to Take Action)

RECOMMENDATION C:

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

Council on Medical Education Report 6 asks 1) That our American Medical Association (AMA) amend Policy H-275.970, Part 5, "Licensure Confidentiality," by addition and deletion to read as follows:

The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is currently suffering from any condition that impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~; and 2) That our AMA encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing

applications to use the language recommended by the American Psychiatric Association that reads, “Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No).”

Your Reference Committee heard unanimous online and in-person testimony in support of this report. Many agreed that reforms in licensure applications are needed to prevent the stigma endured by physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications. In addition to concerns related to stigma, deterred or deferred care seeking, the lack of understanding of impairment vs. illness was also noted. It was suggested that the recommendations in the report be further amended to recognize that licensure application questions should focus on the presence or absence of current impairments that are meaningful in the context of the physician’s practice, competence, and ability to provide safe medical treatment to patients. It was also suggested that licensure applications not seek information about impairment that may have occurred in the distant past and that state medical boards should limit the timeframe for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred. Finally, an amendment was provided to Recommendation 2 to reference recommended language from Federation of State Medical Boards’ policy. Therefore, your Reference Committee recommends that Council on Medical Education Report 6 be adopted as amended.

(8) RESOLUTION 301 - PROTECTING MEDICAL TRAINEES FROM HAZARDOUS EXPOSURE

RECOMMENDATION A:

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

2) That our AMA encourage the Accreditation Council for Graduate Medical Education, ~~and~~ Liaison Committee on Medical Education, and Committee on Osteopathic College Accreditation to create standards that allow all students and trainees to voluntarily avoid exposure to hazardous/biohazard materials without negatively impacting their standing in school or training programs. (New HOD Policy)~~; and be it further~~

RECOMMENDATION B:

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

~~3) That our AMA support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to Methylmethacrylate if they~~

~~are or think they may be pregnant without negatively impacting their standing in their school or training programs (New HOD Policy); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 301 be referred.

RECOMMENDATION D:

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

Resolution 301 asks 1) that our AMA call for the mandatory education of students, residents, physicians and surgeons on the deleterious effects of exposure to hazardous materials; 2) that our AMA encourage the Accreditation Council for Graduate Medical Education and Liaison Committee on Medical Education to create standards that allow students and trainees to voluntarily avoid exposure to hazardous/biohazard materials without negatively impacting their standing in school or training programs; 3) that our AMA support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to Methylmethacrylate if they are or think they may be pregnant without negatively impacting their standing in their school or training programs; and 4) that our AMA support and encourage constant updating of the protection of medical trainees, physicians and surgeons from exposure to hazardous materials during the course of their medical school training and practice, using standards published by the Occupational Safety and Health Administration; the National Institute for Occupational Safety and Health and other Centers for Disease Control and Prevention agencies; the College of American Pathologists; and the American College of Radiology, as well as other relevant resources available for health workers.

Your Reference Committee heard online and in-person testimony in strong support of Resolution 301-A-18, with speakers noting the importance of protecting trainees and colleagues. Weight also was given to the argument that measures of self-protection should not negatively impact one's standing in a training program or workplace. Testimony suggested that the scope of the resolution should be broadened beyond medical students and residents to include physicians and surgeons, and a recommendation was made to widen the scope of the action beyond Methylmethacrylate, specifically to incorporate hazardous materials more generally. However, testimony also was offered stressing the inconclusive findings related to the hazardous, or non-hazardous, nature of various materials. It was also noted that this impacts both men and women. Your Reference Committee agrees with these recommendations. Therefore, your Reference Committee recommends that Resolution 301 be adopted as amended and the final resolve be referred for further study as to what constitutes a hazardous material.

(9) RESOLUTION 302 - FOR-PROFIT MEDICAL SCHOOLS OR COLLEGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 302 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (1) attrition rate of students, (2) financial burden of non-graduates versus graduates, (3) success of graduates in obtaining a residency position, and (4) level of support for graduate medical education, and report back at the 2019 Annual Meeting. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 302 be adopted as amended.

Resolution 302 asks that our AMA study issues related to medical education programs offered at for-profit medical schools and report back at the 2019 Annual Meeting.

Your Reference Committee heard testimony in favor of this item, with the caveat that the scope of the word “issues” was unclear; accordingly, revisions were proferred by the author of the resolution to elucidate the issues the proposed study should encompass. Therefore, your Reference Committee recommends that Resolution 302 be adopted as amended.

(10) RESOLUTION 303 - FELLOWSHIP START DATE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 303 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to ~~survey physicians who have experienced a fellowship start date of August 1st to further~~ evaluate the benefits and drawbacks for all interested parties~~from this transition~~. (Directive to Take Action)

RECOMMENDATION B:

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

Resolution 303 asks that our AMA survey physicians who have experienced a fellowship start date of August 1st to further evaluate the benefits and drawbacks from this transition.

Your Reference Committee heard largely supportive testimony regarding this resolution. Testimony noted the lack of data regarding the impact of different start dates on trainees, programs, and patients. Other testimony alluded to likely universal interest on the part of program directors in data related to this issue. However, other testimony recognized that a survey as outlined in the resolution would lack a comparison group, rendering results less meaningful. Also, the observation was made that our AMA has no purview over the start dates of any fellowship programs, and those organizations that do possess this authority likely would be better suited to study this topic further. Your Reference Committee concurs, however, that our AMA would be a natural partner in this type of endeavor, and therefore recommends that Resolution 303 be adopted as amended.

(11) RESOLUTION 304 - PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES DESIGNATED AS A MEDICALLY UNDERSERVED POPULATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 304 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-90.968 be reaffirmed in lieu of the second Resolve of Resolution 304.

Resolution 304 asks 1) that our AMA advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population, and 2) that our AMA encourage medical schools and graduate medical education programs to include IDD-related competencies and objectives in their curricula.

Your Reference Committee heard online and in-person testimony in support of Resolve 1 of Resolution 304, noting that individuals with intellectual and developmental disabilities represent a unique high-risk population that may require additional health resources beyond those which are readily available to them. A recommendation was made, however, to reaffirm AMA Policy H-90.968, “Medical Care of Persons with Developmental Disabilities,” in lieu of Resolve 2, as existing policy (in particular, sections 4, 7, and 8) already calls for education on this important topic. Therefore, your

Reference Committee recommends that the first Resolve of Resolution 304 be adopted and the second Resolve be reaffirmed.

Policy recommended for reaffirmation:
H-90.968, "Medical Care of Persons with Developmental Disabilities"
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.

(12) RESOLUTION 306 - SEX AND GENDER BASED MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work collaboratively with the Liaison Committee on Medical Education and other interested organizations for the inclusion of sex- and gender-based differences within the ~~mandated~~ curricular content for medical school accreditation.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 306 be changed, to read as follows:

SEX- AND GENDER-BASED MEDICINE

Resolution 306 asks that our AMA work collaboratively with the Liaison Committee on Medical Education for the inclusion of sex-based differences within the mandated curricular content for medical school accreditation.

Your Reference Committee heard unanimous testimony in support of this resolution. This resolution is primarily calling for our AMA to work collaboratively with the Liaison Committee on Medical Education, but it was felt that other organizations may also be interested in working with our AMA on this issue. AMA policy supports the inclusion of women's health issues throughout the basic science and clinical phases of the curriculum. It was also suggested that medical schools should provide opportunities for medical students to learn to recognize and appropriately address sex differences in organ systems during the diagnosis and treatment of patients. Because there are gaps in medical education and training on this topic, it is reasonable to recommend that this topic be included in medical school curricula. A minor amendment was recommended to recognize that our AMA does not support mandating medical school curricula. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

(13) RESOLUTION 311 - OPIOID EDUCATION FOR NEW TRAINEES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 311 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to establish opioid education guidelines for medical students, physicians in training, and practicing physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 311 be adopted as amended.

Resolution 311 asks that our AMA work in conjunction with the Accreditation Council for Graduate Medical Education to establish opioid education guidelines for physicians in training.

Your Reference Committee heard online and in-person testimony in strong support of this resolution. Although our AMA does not typically support curricular mandates, it was felt that this resolution does not represent a mandate as it touches on a topic (opioid prescribing) that is covered in different parts of undergraduate medical education (physiology, pharmacology, the clinical clerkships) and graduate medical education. It was noted that 64,000 people died from opioid overdoses in 2016, and nearly half of all opioid-related deaths involved prescription opioids. However, the level of education on opioids does not seem to be consistent, opioid prescribing practices vary with different regions of practice, and even those who practiced in the same hospital and same specialty have differences in opioid prescription practices. Thus, there was unanimous

support for educational guidelines regarding the practice of prescribing opioid medications. A minor amendment was recommended to expand the organizations that should be involved in establishing opioid education guidelines and to extend the education guidelines across the continuum of medical education. Therefore, your Reference Committee recommends that Resolution 311 be adopted as amended.

(14) RESOLUTION 312 - SUICIDE AWARENESS TRAINING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 312 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association engage with the ~~Liaison Committee on Medical Education~~ appropriate organizations to ~~encourage the inclusion of formalized~~ facilitate the development of educational resources and training related to suicide ~~awareness~~ risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals ~~training~~, using an evidence-based multidisciplinary approach~~, in the curriculum of all accredited medical schools~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 312 be adopted as amended.

Resolution 312 asks that our AMA engage with the Liaison Committee on Medical Education to encourage the inclusion of formalized suicide awareness training, using an evidence-based multidisciplinary approach, in the curriculum of all accredited medical schools.

Your Reference Committee heard universal support for this resolution both online and in person. Testimony strongly encouraged our AMA to take the lead in this critical area, noting that suicide risk can impact patients in addition to physicians, trainees, and other health care professionals. Therefore, your Reference Committee recommends that Resolution 312 be adopted as amended.

(15) RESOLUTION 313 - FINANCIAL LITERACY FOR MEDICAL STUDENTS AND RESIDENTS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association amend policy D-295.316 by addition as follows:

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.

2. Our AMA will work with key stakeholders to advocate for collaborative programs ~~between~~ among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.

3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.

RECOMMENDATION B:

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

Resolution 313 asks that our AMA amend Policy D-295.316 by addition to read as follows:

Management and Leadership for Physicians D-295.316
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.

2. Our AMA will work with key stakeholders to advocate for collaborative programs between medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and financial literacy capabilities.

Your Reference Committee heard testimony that was generally in support of this resolution, which modifies existing policy. Financial literacy is viewed as critical to address the challenge of medical student debt and ensure that medical students are able to make informed financial and career decisions. There was a request to clarify whether the financial literacy initially proposed was personal or professional in nature; language to that effect has been added to address this concern. Therefore, your Reference Committee recommends that Resolution 313 be adopted as amended.

(16) RESOLUTION 315 - PEER-FACILITATED INTERGROUP DIALOGUE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 315 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~work with the AMA Council on Medical Education and Academic Physician Section to~~ encourage ~~the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to include~~ the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 315 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 315 be changed, to read as follows:

PEER-FACILITATED INTERGROUP DIALOGUE TO PROMOTE CULTURAL COMPETENCE AND HUMILITY

Resolution 315 asks that our AMA work with the AMA Council on Medical Education and Academic Physician Section to encourage the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to include peer-facilitated intergroup dialogue in medical education programs nationwide.

Your Reference Committee heard limited but supportive testimony on this resolution. Testimony noted that peer-facilitated dialogue can be an important strategy to address cultural proficiency and cultural humility in medical education, although additional testimony reflected that other types of learning—such as problem-based learning sessions—can also be a part of a larger toolkit used to address this important issue. Your Reference Committee believes that peer-facilitated intergroup dialogue can be a valuable addition to the strategies educational leaders can use to engage learners in cultural humility. Therefore, your Reference Committee recommends that Resolution 315 be adopted as amended.

(17) RESOLUTION 318 - AMA CONVENE STAKEHOLDERS TO TRANSITION USMLE TO PASS / FAIL SCORING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 318 be amended by addition, to read as follows:

3. Our AMA will ~~work with~~ co-convene the appropriate stakeholders to study ~~alternate means of~~ possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates. (Modify Current HOD Policy)

RECOMMENDATION B:

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

Resolution 318 asks that our AMA amend Policy H-275.953, "The Grading Policy for Medical Licensure Examinations," by addition and deletion to read as follows:

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will ~~work with~~ convene the appropriate stakeholders to study ~~alternate means of~~ possible mechanisms for transitioning scoring of the USMLE exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.

Your Reference Committee heard testimony both online and in person largely in favor of Resolution 318. Supporters felt that our AMA should be taking a more proactive role in shaping the medical licensing examination scoring process. A clarifying proposal was made to include the osteopathic licensing examination in addition to the allopathic examination. Testimony elicited the fact that the National Board of Medical Examiners already has launched an initiative that will consider these important issues, and has invited the AMA to be a co-convener. An amendment therefore was proposed that would recognize this planned involvement. After considered discussion, your Reference Committee recommends that Resolution 318 be adopted as amended.

(18) RESOLUTION 305 - STANDARDIZATION OF MEDICAL LICENSING TIME LIMITS ACROSS STATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 305 be referred.

Resolution 305 asks 1) that our AMA amend Policy H-275.978, **"**Medical Licensure," by addition to read as follows**:**

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an

initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX.

Your Reference Committee heard testimony in favor of referring this complex item for further study. Some states have no time limit for completion of the licensing examination sequence; some set a time limit of seven years; and some cap eligibility at 10 years (to accommodate the longer timeline for dual-degree individuals, i.e., those seeking to hold MD and PhD credentials). Testimony was heard concerning the perception that physicians who have academic troubles will take longer to complete the sequence, such that the time limit becomes a mechanism through which to ensure patient safety by eliminating these individuals from the practice of medicine. This belief, however, does not take into account the legitimate health or life issues that may affect a given physician and extend the time needed for completion, or the challenges faced by dual-degree candidates. Testimony in favor of a time limit was that this would ensure that examinees are being assessed based on their current medical knowledge. A comprehensive, holistic review and study of all the relevant factors and consideration of potential unintended consequences is needed, to include all relevant stakeholders, such as the Federation of State Medical Boards and the 70 state medical and osteopathic regulatory boards it represents. Therefore, your Reference Committee recommends that Resolution 305 be referred.

(19) RESOLUTION 307 - HEALTHCARE FINANCE IN THE MEDICAL SCHOOL CURRICULUM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 307 be referred.

Resolution 307 asks 1) That our AMA study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics; and 2) That our AMA make a formal suggestion to the LCME encouraging the addition of a new Element, 7.10, under Standard 7, “Curricular Content,” that would specifically address the role of healthcare finance and medical economics in undergraduate medical education.

Your Reference Committee heard mixed testimony on this resolution. Testimony established that health care finance is already being taught in some medical schools, but an overall understanding of the breadth, depth, and frequency of these offerings is

unknown. Simultaneously, there is concern that the second resolve implies a curricular mandate in an already distended medical education curriculum. Your Reference Committee is sensitive to the concerns of those responsible for curricular integrity, but feels that additional study of this topic is warranted. Therefore, your Reference Committee recommends that Resolution 307 be referred.

(20) RESOLUTION 314 - BOARD CERTIFICATION CHANGES IMPACT ACCESS TO ADDICTION MEDICINE SPECIALISTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 314 be referred.

Resolution 314 asks that our AMA work with the American Board of Addiction Medicine (ABAM) and American Board of Medical Specialties (ABMS) to accept ABAM board certification as equivalent to any other ABMS-recognized Member Board specialty as a requirement to enroll in the transitional maintenance of certification program and to qualify for the ABMS Addiction Medicine board certification examination.

Your Reference Committee heard mixed testimony concerning the requirements for ABMS board certification in addiction medicine, centered around the equivalency of ABAM and ABMS board certification. Although a number of physicians have held ABAM certification, they do not meet the requirements for ABMS subspecialty certification in addiction medicine if they do not hold current ABMS certification in a primary specialty. Specific testimony during the hearing was to explore a pathway leading to lifetime certification. It was also noted that, although certification is not required to practice medicine, there was concern that this may be a requirement for hospital privileges. However, Policy H-275.924 (15), “Maintenance of Certification,” states that “The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.” Although there is an urgent need to address this issue due to the current opioid crisis, your Reference Committee felt that this complex issue required further study, and therefore recommends referral of Resolution 314.

(21) RESOLUTION 316 - END "PART 4 IMPROVEMENT IN MEDICAL PRACTICE" REQUIREMENT FOR ABMS MOC®

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 316 be referred.

Resolution 316 asks that our AMA call for an end to the mandatory American Board of Medical Specialties “Part 4 Improvement in Medical Practice” maintenance of certification requirement.

Your Reference Committee heard mixed testimony regarding the Part 4 requirement for American Board of Medical Specialties (ABMS) maintenance of certification (MOC). There was testimony concerning the relevance, burden, and cost of the MOC Part 4 process in addition to the other requirements physicians are required to fulfill for meaningful use, MACRA, etc. However, it was also noted that the broadening range of acceptable activities that meet the Improvement in Medical Practice (MOC Part 4) component has made this activity acceptable for other national value-based reporting requirements and continuing certification programs. It was also noted that the boards are implementing a number of activities related to registries, systems-based practice, and practice audits to show improvement in practice. The ABMS Multi-Specialty Portfolio Program offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the Improvement in Medical Practice component of the ABMS Program for MOC. Due to the Council on Medical Education's ongoing work with the ABMS and the ABMS member boards to improve this process, your Reference Committee felt that this issue should be referred for further study. Therefore, your Reference Committee recommends that Resolution 316 be referred.

(22) RESOLUTION 317 - EMERGING TECHNOLOGIES (ROBOTICS AND AI) IN MEDICAL SCHOOL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 317 be referred.

Resolution 317 asks 1) That our AMA encourage medical schools to evaluate and update as appropriate their curriculum to increase students' exposure to emerging technologies, in particular those related to robotics and artificial intelligence; 2) That our AMA encourage medical schools to provide student access to computational resources like cloud computing services; 3) That our AMA reaffirm H-480.988 which urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and 4) That our AMA reaffirm Section 1.2.11 of the AMA Code of Ethics and H-480.996 that states the guidelines for the ethical development of medical technology and innovation in healthcare.

Your Reference Committee heard mostly supportive testimony related to Resolution 317. This testimony noted that medical students will need access to these new types of technology to be better prepared for practice. The need for continued ethical guidance also was referenced. In opposition, it was argued that the appropriate place for instruction in these new technologies is at the graduate medical education rather than undergraduate level, as most of these types of technology are specialty specific. Your Reference Committee has been advised that the Council on Medical Education will be presenting a report to the HOD at A-19 on AI across the medical education continuum. Therefore, your Reference Committee recommends that Resolution 317 be referred and considered for inclusion in that report.

(23) RESOLUTION 309 - FOREIGN TRAINED IMGS COMPETENCY-BASED SPECIALTY EXAM WITHOUT U.S. RESIDENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 309 not be adopted.

Resolution 309 asks that our AMA work with other stakeholders including the Accreditation Council of Graduate Medical Education, Association of American Medical Colleges and the American Board of Medical Specialties, to advocate that International Medical Graduates who have completed residency programs in their own countries should be eligible to take the specialties exam without being required to complete additional residency training in the U.S.

Your Reference Committee heard testimony largely in opposition to adoption of Resolution 309. That said, testimony also reflected support for the spirit of this proposal, from a workforce perspective, and as a mechanism to help speed the incorporation of international medical graduates, who provide many invaluable contributions to our society, into the U.S. health care system. It was noted that the current system of requiring an otherwise highly qualified physician from abroad to repeat a residency program in the United States may be archaic, even draconian, but that replacing this imperfect system with a single year of residency or a multiple-choice board certification examination is problematic at best. The systems of education, accreditation, and certification throughout the world are highly variable; allowing for an overly open system could put patients at risk. Another potential scenario presented through testimony was concerning as well: A U.S. medical school graduate who was unable to enter into a residency program here could go outside the U.S. for graduate medical education and then return through this proposed pathway. Additional testimony noted that accredited residency programs in the U.S. have aspects that are unique, including the six general competencies of the Accreditation Council for Graduate Medical Education (ACGME). Further, completing an ACGME-accredited residency program goes beyond clinical aspects, by helping acculturate IMGs to the practice and culture of medicine and health care in the U.S., which may be drastically different from that of their home countries. Finally, some member boards of the American Board of Medical Specialties already offer special accelerated pathways to practice for IMGs who meet specific metrics. For all these reasons, your Reference Committee therefore recommends that Resolution 309 not be adopted.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Grayson Armstrong, MD, MPH; Cheryl Gibson Fountain, MD; Alan K. Klitzke, MD; David N. Lewin, MD; Kimberly Jo Templeton, MD; and Jessica Walsh O'Sullivan, and all those who testified before the committee, as well as our AMA staff, including Catherine Welcher, Carrie Radabaugh, Fred Lenhoff, Victoria Elliott, and Alejandro Aparicio, MD.

Grayson Armstrong, MD, MPH
Ophthalmology

David N. Lewin, MD
Pathology

Cheryl Gibson Fountain, MD
(Alternate) Michigan

Kimberly Jo Templeton, MD
Orthopaedic Surgery

Alan K. Klitzke, MD
Nuclear Medicine

Jessica Walsh O'Sullivan
Florida

Sherri S. Baker, MD
Oklahoma
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee D

Shannon Kilgore, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 11 – Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States
2. Council on Science and Public Health Report 1 – CSAPH Sunset Review of 2008 House of Delegates Policies
3. Resolution 405 – Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data
4. Resolution 411 – Reporting Child Abuse in Military Families
5. Resolution 423 – Grill Brush Warning
6. Resolution 432 – Legal Action to Compel FDA to Regulate E-Cigarettes
7. Resolution 434 – Health Care Workplace Ergonomics

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

8. Board of Trustees Report 28 – Mandatory Public Health Reporting of Law Enforcement-Related Injuries and Deaths
9. Council on Science and Public Health Report 4 – The Physician's Role in Firearm Safety
10. Council on Science and Public Health Report 5 – Tobacco Harm Reduction: A Comprehensive Policy to Reduce Death and Disease Caused by Smoking
11. Resolution 401 – Danger from Bright Vehicle Headlights
12. Resolution 402 – Schools as Gun-free Zones
13. Resolution 404 – Emphasizing the Human Papillomavirus Vaccine as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic
14. Resolution 407 – Support for Research of Boxes for Babies' Sleeping Environment
15. Resolution 408 – Ending Money Bail to Decrease Burden on Lower Income Communities
16. Resolution 409 – Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities
17. Resolution 412 – Reducing the Use of Restrictive Housing in Prisoners with Mental Illness
18. Resolution 414 – Sex Education Materials for Students with Limited English Proficiency
19. Resolution 416 – Medical Respite Care for Homeless Adults
20. Resolution 417 – Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care
21. Resolution 418 – A Guide for Best Health Practices for Seniors Living in Retirement Communities
22. Resolution 421 – Product Date Labels

23. Resolution 422 – School Drinking Water Quality Testing, Monitoring, and Maintenance
24. Resolution 424 – Rape and Sexual Assault on College Campuses
25. Resolution 425 – Hospital Food Labeling
26. Resolution 426 – Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs
27. Resolution 427 – Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms
28. Resolution 428 – LGBTQIA+ Inclusive Sex Education Alongside Heterosexual Sex Education
29. Resolution 429 – E-Cigarette Ingredients

RECOMMENDED FOR REFERRAL

30. Board of Trustees Report 27 – Policy and Economic Support for Early Child Care
31. Resolution 410 – Opposition to Measures that Criminalize Homelessness
32. Resolution 413 – Improving Safety and Health Code Compliance in School Facilities
33. Resolution 430 – Vector-Borne Diseases
34. Resolution 431 – Low Nicotine Cigarette Product Standard

RECOMMENDED FOR REFERRAL FOR DECISION

35. Resolution 419 – Violence Prevention
36. Resolution 433 – Firearm Safety

RECOMMENDED FOR NOT ADOPTION

37. Resolution 420 – Mandatory Influenza Vaccination Policies for Healthcare Workers

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

38. Resolution 403 – School Safety and Mental Health

Resolutions handled via the Reaffirmation Consent Calendar:
Resolution 406 – Support for Public Health Violence Prevention Programs
Resolution 415 – Reducing Gun Violence in America

(1) BOARD OF TRUSTEES REPORT 11 - HOUSING PROVISION AND SOCIAL SUPPORT TO IMMEDIATELY ALLEVIATE CHRONIC HOMELESSNESS IN THE UNITED STATES

RECOMMENDATION:

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

Board of Trustees Report 11 recommends that Policy, H-160.903, "Eradicating Homelessness," be amended to recognize that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless. Furthermore, adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.

Your Reference committee heard support for Board of Trustees Report 11. The positive impact of stable and affordable housing was noted in testimony, along with the effectiveness of Housing First in improving quality of life in those who are homeless. While one individual spoke regarding the need to address chronically homeless individuals with substance use disorders, your Reference Committee felt that this was addressed by noting the need for adaptive strategies based on regional variations and community characteristics. Therefore, your Reference Committee agrees that Board of Trustees Report 11 be adopted.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - CSAPH SUNSET REVIEW OF 2008 HOUSE OF DELEGATES POLICIES

RECOMMENDATION:

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

Council on Science and Public Health Report 1 presents the Council's recommendations on the disposition of House policies from 2008 that were assigned to it. The report recommends that the House of Delegate policies that are listed in the Appendix to the report be acted upon in the manner indicated and the remainder of the report be filed.

There were no concerns raised regarding the Council on Science and Public Health's Sunset Review of 2008 House of Delegate Policies. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted.

(3) RESOLUTION 405 - RACIAL HOUSING SEGREGATION AS A DETERMINANT OF HEALTH AND PUBLIC ACCESS TO GEOGRAPHIC INFORMATION SYSTEMS (GIS) DATA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 405 be adopted.

Resolution 405 asks that our American Medical Association oppose policies that enable racial housing segregation and advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development Affirmatively Furthering Fair Housing tool.

Your Reference Committee heard unanimous support for Resolution 405. Your Reference Committee agrees that racial housing segregation is a contributing factor to health disparities. Geographic Information Systems (GIS) data is a critical tool for public health researchers to map and address health disparities. Therefore, your Reference Committee recommends that Resolution 405 be adopted.

(4) RESOLUTION 411 - REPORTING CHILD ABUSE IN MILITARY FAMILIES

RECOMMENDATION:

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

Resolution 411 asks that our American Medical Association support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.

Your Reference Committee heard unanimous support for Resolution 411. It was noted that child abuse and neglect is underreported in military families. Your Reference Committee agrees that our American Medical Association should support state and federal-run child protective services in reporting child abuse and neglect brought to their attention to the Family Advocacy Program within the Department of Defense. It was suggested that our American Medical Association may want to consider contacting state governors to advocate for this policy. Therefore, your Reference Committee recommends that Resolution 411 be adopted.

(5) RESOLUTION 423 - GRILL BRUSH WARNING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 423 be adopted.

Resolution 423 asks that our American Medical Association request that the appropriate federal agency require the placement of a warning label on all wire-bristle grill brushes informing consumers about the possibility of wire bristles breaking off and being accidentally ingested.

Your Reference Committee heard limited testimony supporting Resolution 423. Your Reference Committee agrees that it is important to increase awareness among consumers, manufacturers, retailers, and medical professionals to promote prevention, timely diagnosis, and appropriate treatment of grill brush injuries. Therefore, your Reference Committee recommends that Resolution 423 be adopted.

(6) RESOLUTION 432 - LEGAL ACTION TO COMPEL FDA TO REGULATE E-CIGARETTES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 432 be adopted.

Resolution 432 asks that our American Medical Association consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.

Your Reference Committee heard testimony in support of Resolution 432. Your Reference Committee agrees that our American Medical Association should consider joining in an amicus brief to compel the Food and Drug Administration to take timely action to regulate e-cigarettes, cigars and other nicotine tobacco products. Your Reference Committee agrees that the FDA is putting children at risk by allowing e-cigarettes, cigars and other nicotine tobacco products to stay on the market without adequate information about their impact. Therefore, your Reference Committee recommends that Resolution 432 be adopted.

(7) RESOLUTION 434 – WORKPLACE ERGONOMICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 434 be adopted.

Resolution 434 asks that our American Medical Association (1) support research on reducing physician and staff ergonomic injuries in the health care workplace, including but not limited to studying medical instrument and work station design and development; and (2) work with resident training programs, hospitals and other interested parties to help integrate evidence-based ergonomics programs with other types of wellness programs for physicians and medical staff.

Resolution 434 also asks that our AMA advocate for legislation that would: (1) appropriate an adequate percentage of research dollars to National Institutes of Health (NIH), NIH Institutes, National Science Foundation (NSF), The National Institute for Occupational Safety and Health (NIOSH), and National Academy of Medicine for basic and advanced research of health care workplace ergonomics; and (2) require that such research be focused on practicing physicians, with practicing physicians as Principal Investigators.

Your Reference Committee heard testimony in support of Resolution 434. Testimony noted that work-related disorders in physicians are often underreported and receive little attention because of the constraints of studying ergonomics. It was noted in testimony that it is cheaper to prevent an injury than to treat it. Your Reference Committee agrees that workplace ergonomics are an important aspect to physician health. Therefore, your Reference Committee recommends that Resolution 434 be adopted.

(8) BOARD OF TRUSTEES REPORT 28 - MANDATORY PUBLIC HEALTH REPORTING OF LAW ENFORCEMENT-RELATED INJURIES AND DEATHS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 28 be amended by addition to read as follows:

1. That current AMA Policy H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes,” be amended by addition and deletion to read as follows:

H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes”

Our AMA: 1. ~~Our AMA~~ E~~e~~ncourages the National Academies of Sciences, Engineering, and Medicine and other interested parties

to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities. 2. ~~Our AMA~~ A~~a~~ffirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. 3. ~~Our AMA~~ E~~e~~ncourages the Centers for Disease Control and Prevention as well as state and local public health ~~departments and~~ agencies to research the nature and public health implications of violence involving law enforcement. 4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. 5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define "serious injuries" for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers. (Modify Current HOD Policy)

RECOMMENDATION B:

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

The Board of Trustees Report 28 examines the reporting of law enforcement-related injuries and deaths. The report recommends amending AMA Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," to encourage states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. The report also recommends reaffirming existing Policy, H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," which supports increased funding for and the expansion of the National Violent Death Reporting System to all 50 states and territories.

Your Reference Committee heard testimony that was mostly supportive of the recommendations in Board of Trustees Report 28. Some concerns were raised that the report did not address the issue of serious injuries. Your Reference Committee notes the report discusses the numerous definitions of "law enforcement-related deaths" and recognizes that the term "serious injuries" is even less clear. Your Reference Committee felt that a good starting point to address this issue would be to develop a common definition of the types of injuries that should be reported. Your Reference Committee also heard testimony about the need to include deaths while in custody and felt that while this is an important issue, it is difficult to define law-enforcement related deaths. Your Reference Committee felt it was best to stick with the term legal-intervention death as recommended in the report. Therefore, Your Reference Committee recommends that Board of Trustees Report 28 be adopted as amended.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 - THE PHYSICIAN'S ROLE IN FIREARM SAFETY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Science and Public Health Report 4 be amended by addition and deletion to read as follows:

Firearms and High-Risk Individuals
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, ~~or~~ convicted of misdemeanor domestic violence crimes or stalking, ~~including dating partners,~~ from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (~~4~~5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (~~5~~6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (New HOD Policy)

RECOMMENDATION B:

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

Council on Science and Public Health Report 4 is a Council initiated report focused on the role of physicians in promoting firearm safety. The report recommends that our AMA support: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders or convicted of misdemeanor domestic violence crimes, including dating partners, from possessing or purchasing firearms; (3) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (4) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (5) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. The report also recommends amending Policy H-145.975, “Firearm Safety and Research,

Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," to (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

The Council was thanked for their thoughtful and informative report on this timely issue. Testimony was unanimously supportive of the recommendations in this report. It was noted that physicians should be leaders on this issue and the recommendations in the report are a step in the right direction. There was also support for Resolutions 419 and 433, which address similar issues. It was felt that the language in the Council's recommendations was more comprehensive than that of the resolutions addressing similar topics. Your Reference Committee did feel that the issue of stalking, which was referenced in Resolution 433, should be referenced in policy. Therefore, your Reference Committee recommends that CSAPH Report 4 be adopted as amended.

(10) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 - TOBACCO HARM REDUCTION: A COMPREHENSIVE NICOTINE POLICY TO REDUCE DEATH AND DISEASE CAUSED BY SMOKING

RECOMMENDATION A:

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

1. That Policy H-495.988, "FDA Regulation of Tobacco Products," be amended by addition and deletion to read as follows:

H-495.988 FDA Regulation of Tobacco Products
1. Our AMA: (A) ~~reaffirms its position~~ acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and ~~is associated with~~ increases youth risk of ~~the~~ usinge ~~of~~ combustible tobacco cigarettes ~~in youth~~; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D~~B~~) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E~~C~~) reaffirms

its position that the Food and Drug Administration (FDA) does ~~have,~~ and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F~~D~~) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G~~E~~) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (H~~F~~) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I~~G~~) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products… (Amend Current HOD Policy)

RECOMMENDATION B:

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

2. That Policy H-495.972, “Electronic Cigarettes, Vaping, and Health: 2014 Update,” be amended by addition and deletion to read as follows, with a change in title:

Electronic Cigarettes, Vaping, and Health~~: 2014 Update~~
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine

overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes. ;3. Our AMA (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes.; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction. (Amend Current HOD Policy)

RECOMMENDATION C:

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

Council on Science and Public Health Report 5 examined the available evidence on the use of non-combustible tobacco products for the purposes of harm reduction. The report recommends amending exiting Policy, H-495.988 "FDA Regulation of Tobacco Products" to recognize that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and is associated with the use of combustible tobacco cigarettes in youth. The policy also encourages long-term studies of vaping and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal. The report also recommends that Policy H-495.972, "Electronic Cigarettes, Vaping, and Health: 2014 Update," be amended to recognize that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.

Your Reference Committee heard mostly supportive testimony on the recommendations in Council on Science and Public Health Report 5. The American Academy of Pediatrics offered an amendment to strengthen the language around the increased risk of smoking combustible tobacco cigarettes by those youth who use electronic cigarettes. The Council on Science and Public Health supported this amendment. An additional proposed amendment suggested striking the language noting that the evidence pointing to there being fewer toxicants in electronic cigarettes. The Council noted that while this may not be popular, it reflects the current state of the evidence. Additional amendments specified that the education on e-cigarettes should focus on the health effects. Your Reference Committee agreed with this sentiment. While some spoke to referral of the report, your Reference Committee noted that the majority of those who testified supported adoption. Therefore, Your Reference Committee recommends the adoption of Council on Science and Public Health Report 5 as amended.

(11) RESOLUTION 401 - DANGER FROM BRIGHT VEHICLE HEADLIGHTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 401.

ADAPTIVE DRIVING BEAM HEADLIGHTS
RESOLVED, That our American Medical Association encourage the National Highway Traffic Safety Administration to undertake the necessary rulemaking to integrate automated high-beam to low-beam headlight switching lamps into the Federal Motor Vehicle Safety Standards. (Directive to Take Action)

Resolution 401 asks that our American Medical Association: (1) study the danger of bright vehicle headlights and report back to the House of Delegates, (2) study the safety risks to drivers and their passengers when they approach vehicles with incandescent, xenon gas or LED headlights, as well as the use of other technologies such as automated steering and automated windshield tinting to mitigate the risks, (3) advocate for mandatory automated high-beam to low-beam headlight switching systems that would operate when an approaching vehicle headlight is detected.

Your Reference Committee heard limited, but supportive testimony on Resolution 401. The Council on Science and Public Health noted that incandescent, xenon gas, and LED headlights currently meet the intensity requirements specified in the Federal Motor Vehicle Safety Standards (FMVSS). However, NHTSA is sponsoring research to determine what changes may need to be made to the lighting standard to ensure the appropriate balance between visibility and glare. Since this research is underway, the AMA should not undertake this study. The Council did note the need to update the FMVSS to facilitate the integration of automated high-beam to low-beam headlight switching lamps into the current standard as this technology is being utilized in other countries. Your Reference Committee agrees and recommends the amended language in lieu of Resolution 401.

(12) RESOLUTION 402 - SCHOOLS AS GUN-FREE ZONES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 402 be amended by addition to read as follows:

RESOLVED, that our AMA advocate for schools to remain gun-free zones except for school-sanctioned activities, and be it further

RECOMMENDATION B:

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

Resolution 402 asks that our American Medical Association advocate for schools to remain gun-free zones and oppose requirements or incentives of teachers to carry weapons.

Your Reference Committee heard extensive testimony on this resolution, existing policy already encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property. Testimony suggested that there be exceptions for military schools as well as the use of guns that fire non-lethal projectiles as used in some sports. Your Reference Committee addressed this by adding an exception for school-sanctioned activities. Your Reference Committee also heard strong support regarding the need for those who carry weapons to undergo extensive training. There was agreement that allowing teachers to carry weapons may exacerbate the problem so the Reference Committee retained the second Resolve. Your Reference Committee recommends that Resolution 402 be adopted as amended.

(13) RESOLUTION 404 - EMPHASIZING THE HUMAN PAPILLOMAVIRUS VACCINES AS ANTI-CANCER PROPHYLAXIS FOR A GENDER-NEUTRAL DEMOGRAPHIC

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-170.995 be amended by addition and deletion to read as follows:

Human Papillomavirus (HPV) Inclusion in ~~High~~ School Education Curricula

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in ~~both males and females~~ all genders, the causal relationship of (HPV) to genital lesions and ~~cervical~~ cancer~~, and the importance of routine pap smears in the early detection of cervical cancer;~~ (2) urge that students and parents be educated about (HPV) and the availability of the (HPV) vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that policy D-170.995 be adopted as amended in lieu of Resolution 404.

Resolution 404 asks that our American Medical Association acknowledge HPV vaccines as beneficial to all genders as anti-cancer and anti-STI and support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs.

Your Reference Committee heard testimony in strong support of Resolution 404. Your Reference Committee felt that this was best addressed by amending existing policy on HPV and broadening that policy to address the relationship between HPV and cancer beyond just cervical cancer. It was noted that HPV vaccination should occur before kids are in high school, so the title of the policy has been amended to reflect that. Therefore, your Reference Committee recommends that Resolution 404 be adopted as amended.

(14) RESOLUTION 407 - SUPPORT FOR RESEARCH OF BOXES FOR BABIES' SLEEPING ENVIRONMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 407 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~support the~~ encourage further research of infant safe sleeping environment programs, ~~which could include~~ including, but not limited to, the study of the safety and efficacy of boxes ~~for babies to sleep in as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 407 be adopted as amended.

Resolution 407 asks that our American Medical Association support the research of safe sleeping environment programs, which could include the study of the safety and efficacy of boxes for babies to sleep in as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States.

The author of this resolution offered a friendly amendment drafted in collaboration with the American Academy of Pediatrics. Testimony noted that baby box programs have been implemented in Finland and research is underway there to determine the effectiveness of baby boxes in reducing sudden unexpected infant deaths. These programs have also been implemented in some states. Your Reference Committee

heard extensive testimony in support of the amended resolution. Therefore, our Reference Committee recommends that Resolution 407 be adopted as amended.

(15) RESOLUTION 408 - ENDING MONEY BAIL TO DECREASE BURDEN ON LOWER INCOME COMMUNITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 408 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (1) recognize the adverse health effects of pretrial detention; and (2) support legislation that ~~ends~~ promotes the use of non-financial ~~pretrial financial~~ release options for individuals charged with nonviolent crimes. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 408 be adopted as amended.

Resolution 408 asks that our American Medical Association support legislation that ends pretrial financial release options for individuals charged with nonviolent crimes.

Your Reference Committee heard limited testimony, which was in favor of Resolution 408. The authors offered an amendment to clarify that pretrial detention leads to adverse health effects to promote the use of non-financial release options, rather than ending pretrial financial release, for those with violent crimes. Support was offered for the amended language. Your Reference Committee agrees that the amended language should be adopted.

(16) RESOLUTION 409 - FOOD ADVERTISING TARGETED TO BLACK AND LATINO YOUTH CONTRIBUTES TO HEALTH DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 409 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend Policy H-60.972 by addition and deletion to read as follows:

(1) It is the policy of ~~the~~ our AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children~~.~~; and (2) ~~The~~ Our AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA, when such marketing targets youth ~~toward youth, from~~ especially vulnerable populations; (Modify Current HOD Policy) and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 409 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 409 be changed to read as follows:

FOOD ADVERTISING TARGETED TO YOUTH

Resolution 409 asks that our American Medical Association: (1) establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations; (2) amend Policy H-60.972, "Banning Food Commercials Aimed at Children," by addition and deletion to read as follows: (1) It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children.; and (2) The AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward youth from vulnerable populations.; and (3) work with the appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations.

Your Reference Committee heard supportive testimony for this resolution. Testimony was heard suggesting that the scope of the resolution should be expanded to all youth, but especially vulnerable populations. Your Reference Committee agreed with this language, and therefore recommends that Resolution 409 be adopted as amended.

(17) RESOLUTION 412 - REDUCING THE USE OF RESTRICTIVE HOUSING IN PRISONERS WITH MENTAL ILLNESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 412 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; and be it further

RESOLVED, that our AMA support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health processionals; and be it further

RESOLVED, That our American Medical Association encourage ~~federal, state, local, and private correctional facilities~~ appropriate stakeholders to ~~explore,~~ develop~~,~~ and implement alternatives to ~~restrictive housing~~ solitary confinement for ~~inmates with mental illness in order to reduce and ultimately eliminate the use of restrictive housing in this population~~ incarcerated persons in all correctional facilities. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 412 be adopted as amended.

Resolution 412 asks that our American Medical Association encourage federal, state, local, and private correctional facilities to explore, develop, and implement alternatives to restrictive housing for inmates with mental illness in order to reduce and ultimately eliminate the use of restrictive housing in this population.

The author of this resolution submitted amended language which included the addition of two resolves and an amended original (third) resolve. Your Reference Committee heard testimony in support of the amended resolution. Limited testimony was also heard regarding the need for solitary confinement in some situations where the safety of the patient or provider is at risk. As a result, the Reference Committee made further edits to allow for exceptions in rare circumstances. Your Reference Committee recommends that Resolution 412 be adopted as amended

(18) RESOLUTION 414 - SEX EDUCATION MATERIALS FOR STUDENTS WITH LIMITED ENGLISH PROFICIENCY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 414 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend policy H-170.968 by addition as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; and (h) include culturally competent materials that are language-appropriate ~~concordant~~ for Limited English Proficiency (LEP) pupils; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence

while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-170.968 be <u>adopted in lieu of Resolution 414</u>.

Resolution 414 asks that our American Medical Association amend policy H-170.968 by addition as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; and (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Your Reference Committee heard testimony in support of this resolution. Testimony asked that the word “concordant” in the new clause be changed to “appropriate”. Your Reference Committee agrees with this friendly amendment and therefore recommends that Resolution 414 be adopted as amended.

(19) RESOLUTION 416 - MEDICAL RESPITE CARE FOR HOMELESS ADULTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 416 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 416 be adopted as amended.

Resolution 416 asks that our American Medical Association study funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

Very limited, but supportive testimony was heard in favor of this resolution. The Council on Science and Public Health testified that the National Health Care for the Homeless Council (NHCHC) released standards for Medical Respite Care in 2016 to improve quality and consistency across a range of medical respite programs. These standards provide a framework to help programs operate safely and effectively. The Council felt that the NHCHC was in a better position to study this issue than the AMA. Your Reference Committee agrees with the Council and therefore, recommends that Resolution 416 be adopted as amended.

(20) RESOLUTION 417 - REDUCING DISPARITIES IN OBSTETRIC OUTCOMES, MATERNAL MORBIDITY, AND PRENATAL CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 417 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices ~~in ethnic minorities~~ to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal

mortality in racial and ethnic minorities. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 417 be adopted as amended.

Resolution 417 asks that our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices in ethnic minorities to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality.

Your Reference Committee heard ample testimony in support of this resolution. Testimony asked that "racial" be added to the phrase "in ethic minorities" and that this phrase be moved to the end of the statement in order to make it clearer. Your Reference Committee agrees and therefore recommends that Resolution 417 be adopted as amended.

(21) RESOLUTION 418 - A GUIDE FOR BEST HEALTH PRACTICES FOR SENIORS LIVING IN RETIREMENT COMMUNITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 418 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association, urge appropriate organizations, including, but not limited to ~~in cooperation with other interested parties such as the public health community,~~ geriatric and other relevant medical specialties, the public health community, and AARP, to ~~study the~~ develop~~ment of a document that could~~ guidance on best health practices for the senior independent living community. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 418 be adopted as amended.

Resolution 418 asks that our American Medical Association, in cooperation with other interested parties such as the public health community, geriatric specialties, and AARP, study the development of a document that could guide best health practices for the senior independent living community.

Your Reference Committee heard testimony in support of Resolution 418. The Council on Science and Public Health noted that this resolution is broadly consistent with AMA policy, but that other organizations, such as AARP have already developed some recommendations on best practices for the senior independent living community. It was noted that, while physician input is needed, the AMA may not be in the best position to take the lead on this as there are other organizations that have a long-standing presence in this field. Your Reference Committee agrees and therefore recommends the adoption of Resolution 418 as amended.

(22) RESOLUTION 421 - PRODUCT DATE LABELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 421 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~endorse~~ support federal standardization of date labels on food~~s and other~~ products to ensure that ~~they~~ the labels address safety concerns. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 421 be adopted as amended.

Resolution 421 asks that our American Medical Association endorse federal standardization of date labels on foods and other products to ensure that they address safety concerns.

Your Reference Committee heard supportive testimony for this resolution due to consumer confusion and the lack of an existing standard for food labels to ensure product safety. Your Reference Committee offers amendments to clarify the intent of the resolution, and acknowledges that “food products” includes beverages. As such, your Reference Committee recommends that Resolution 421 be adopted as amended.

(23) RESOLUTION 422 - SCHOOL DRINKING WATER QUALITY TESTING, MONITORING, AND MAINTENANCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-135.928 be amended by addition to read as follows:

Safe Drinking Water
Our AMA supports updates to the U.S. Environmental Protection Agency’s Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead

through drinking water by: (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;(2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations; (3) Informing consumers about the health-risks of partial lead service line replacement; (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems; (5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers; (~~5~~6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health; (~~6~~7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations; (~~7~~8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; and (~~8~~9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act~~.~~; (10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-135.928 be adopted in lieu of Resolution 422.

Resolution 422 asks that our American Medical Association amend policy H-60.918 by addition to read as follows:

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should

include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water.
5. Our AMA supports the creation and implementation of standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers (Modify Current HOD Policy); and that our AMA actively pursue changes to the federal lead and copper rules consistent with AMA policy H-135.928.

Your Reference Committee heard testimony unanimously in support of this resolution. Your Reference felt that the proposed amendments did not fit well in Policy H-60.918, which deals with screening and support for people exposed to lead. Your Reference Committee felt that the amendments fit better in the AMA's existing policy on safe drinking water and have incorporated them accordingly.

(24) RESOLUTION 424 - RAPE AND SEXUAL ABUSE ON COLLEGE CAMPUSES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 424 be amended by addition to read as follows:

RESOLVED, That our American Medical Association work with relevant stakeholders to ~~evaluate~~ address the issues of rape, sexual abuse, and physical abuse on college campuses ~~and the role state medical societies and our AMA can play in helping to address and resolve these issues~~ (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 424 be adopted as amended.

Resolution 424 asks that our American Medical Association evaluate the issues of rape, sexual abuse, and physical abuse on college campuses and the role state medical societies and our AMA can play in helping to address and resolve these and strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.

Your Reference Committee heard supportive testimony for this resolution and believes that it can best be addressed in collaboration with the leading organizations already working on this issue. Working with relevant stakeholders encompasses state medical

societies. Therefore your Reference Committee recommends that Resolution 424 be adopted as amended.

(25) RESOLUTION 425 - HOSPITAL FOOD LABELING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 425 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA modify Policy H-150.949 by addition to read as follows:

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy~~ful~~ food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy~~ful~~ beverages.
3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information ~~similar to what is being required for chain restaurants~~.
(Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 425 be adopted as amended.

Resolution 425 asks that our American Medical Association modify Policy H-150.949 by addition to read as follows:

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises. 2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthful food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthful beverages. 3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information similar to what is being required for chain restaurants. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of this resolution. The resolution calls for an amendment to current policy to add a third clause. Testimony supported the removal of the reference to restaurants in the new clause. Your Reference Committee

agrees with the removal, as guidelines for chain restaurants may change and the AMA should support nutrition information in hospital settings regardless. Your Reference Committee also changed "healthful" to "healthy" for consistency with the title. Therefore your Reference Committee recommends that Resolution 425 be adopted as amended.

(26) RESOLUTION 426 - DECREASE ADOLESCENT MORTALITY THROUGH MORE COMPREHENSIVE GRADUATED DRIVER LICENSING PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 426 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~the standardization and implementation of~~ more comprehensive Graduated Driver Licensing programs including but not limited to ~~increasing~~ more stringent permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 426 be adopted as amended.

Resolution 426 asks that our American Medical Association support the standardization and implementation of more comprehensive Graduated Driver Licensing programs including but not limited to increasing permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions.

Your Reference Committee heard testimony in support of this resolution. It was noted that while all states have adopted some form of graduated drivers licensing program, few of them incorporate best practices as identified by leading national organizations. An amendment was proposed to encourage working towards more comprehensive graduated drivers licensing programs rather than the standardization and implementation of such programs. Your Reference Committee agrees with the amendment. It was also noted in testimony that state medical associations should be working to address this issue. Your Reference Committee recommends the adoption of Resolution 426 as amended.

(27) RESOLUTION 427 - SUPPORT GUN BUYBACK PROGRAMS IN ORDER TO REDUCE THE NUMBER OF CIRCULATING UNWANTED FIREARMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 427 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association supports the ~~institution~~ concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 427 be adopted as amended.

Resolution 427 asks that our American Medical Association support the institution of gun buyback programs.

Your Reference Committee heard testimony in support of the concept of gun buyback programs. Your Reference Committee agrees that this may be one of many approaches needed to address the issue. Testimony also noted the need for destruction of guns in such programs. However, it was also noted that there is not currently evidence to support gun buyback programs as a method to reduce violence. Your Reference Committee believes that research should be conducted on gun buyback programs, to determine the best approach to designing these programs in a manner that reduces firearm injuries and deaths.

(28) RESOLUTION 428 - LGBTQIA+ INCLUSIVE SEX EDUCATION ALONGSIDE HETEROSEXUAL SEX EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy, H-170.968 be amended by addition to read as follows:

Our AMA:
(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (hg) are part of an overall health education program;…

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 428 be adopted as amended.

Resolution 428 asks that our American Medical Association update the policy on Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools to mandate inclusive sexuality education in all schools.

Testimony was supportive of Resolution 428. The author offered the above amendment, which clarified the language that should be included in existing AMA policy, the terminology of which is consistent with other existing AMA policy. Your Reference Committee agreed with this language and recommends that Resolution 428 be adopted as amended.

(29) RESOLUTION 429 - E-CIGARETTE INGREDIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 429 be amended by addition to read as follows:

RESOLVED, That our American Medical Association urge federal officials, including but not limited to the U.S. Food and Drug Administration (FDA), to prohibit the sale of any e-cigarette cartridges and e-liquid refills that does not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling) (New HOD Policy);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 429 be amended by addition to read as follows:

RESOLVED, That our AMA urge federal officials, including but not limited to the FDA, to require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 429 be adopted as amended.

Resolution 429 asks that our American Medical Association urge federal officials, including but not limited to the U.S. Food and Drug Administration (FDA), to prohibit the sale of any e-cigarette cartridge that does not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling) and to require that an accurate nicotine content of e-cigarettes be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Your Reference Committee heard testimony that was unanimously in support of Resolution 429. However, testimony was heard that in addition to e-cigarette cartridges, e-liquid refills should also be labeled. Your Reference Committee agrees and recommends adoption of 429 as amended.

(30) BOARD OF TRUSTEES REPORT 27 - POLICY AND ECONOMIC SUPPORT FOR EARLY CHILD CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 27 be referred.

The Board of Trustees Report 27 recommends that our AMA: (1) reaffirm Policy H-440.823, “Paid Sick Leave,” which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member, (2) encourage employers to offer and/or expand paid parental leave

policies, (3) encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies.

Your Reference Committee heard testimony in support and in favor of referral for Board of Trustees Report 27. It was noted that approximately 38 percent of employers offer paid leave for new parents. It was also noted that small businesses and practices suffer when employees go on leave, as these small businesses and practices lose funding sources when employees go on leave, affecting the other employees at the organization. It was also suggested numerous times in the testimony to go back to the original resolution language. Therefore, your Reference Committee recommends that Board of Trustees Report 27 be referred back for additional study.

(31) RESOLUTION 410 - OPPOSITION TO MEASURES THAT CRIMINALIZE HOMELESSNESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 410 be referred.

Resolution 410 asks that our American Medical Association oppose measures that criminalize necessary means of living among homeless persons, including but not limited to, sitting or sleeping in public spaces and advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights.

Your Reference Committee heard mixed testimony on Resolution 410. It was noted in testimony that criminalization is costly, and current laws are counter-productive. Your Reference Committee agrees that our American Medical Association should oppose measures that criminalize necessary means of living among homeless persons, including but not limited to, sitting or sleeping in public spaces and advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights. Your Reference Committee also recognizes that this problem requires complex solutions and need to be balanced against possible public health concerns and nuisance laws. Further research is needed on this topic. Therefore, your Reference Committee recommends that Resolution 410 be referred.

(32) RESOLUTION 413 - IMPROVING SAFETY AND HEALTH CODE COMPLIANCE IN SCHOOL FACILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 413 be referred.

Resolution 413 asks that our American Medical Association support: (1) the development and implementation of standardized, comprehensive guidelines for school safety and health code compliance inspections, (2) policies aiding schools in meeting said guidelines, including support for financial and personnel-based aid for schools based in vulnerable neighborhoods, and (3) creation of a streamlined reporting system

for school facility health data potentially through application of current health infrastructure.

Your Reference Committee heard testimony in support of referral for Resolution 413. Testimony noted that there are already extensive guidelines provided for schools by the Centers for Disease Control, Environmental Protection Agency, and state Departments of Health. It was noted that our American Medical Association should review the guidelines from these sources. It was noted that education is a social determinant of health, and communities are often constrained in resources. It was also noted that there is no governing body that enforces the compliance of safety standards in schools. Therefore, your Reference Committee recommends that Resolution 413 be referred.

(33) RESOLUTION 430 - VECTOR-BORNE DISEASES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first and second Resolves of Resolution 430 be referred.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 430 be adopted.

Resolution 430 asks that our American Medical Association: (1) study the emerging epidemic of vector-borne diseases including an analysis of currently available testing and treatment standards and their effectiveness, (2) issue a white paper on vector-borne diseases for the purpose of increasing awareness of the epidemic of vector-borne diseases, and (3) advocate for local, state and national research, education, reporting and tracking on vector-borne diseases.

Your Reference Committee heard strong testimony in support of the overall resolution. However, a number of amendments were also proposed. Your Reference Committee recommends referral of the first and second Resolves since there were amendments for consideration and they call for a study. Your Reference Committee feels that it is important in the meantime to have AMA policy on the books that addresses the need for the AMA to advocate for research, education, reporting, and tracking of vector-borne disease. As such, your Reference Committee recommends adoption of the third Resolve.

(34) RESOLUTION 431 - LOW NICOTINE CIGARETTE PRODUCT STANDARD

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 431 be referred.

Resolution 431 asks that our American Medical Association develop a report on the individual health and public health implications of a low nicotine standard for cigarettes. Such a report should consider and make recommendations on scientific criteria for selection of a nicotine standard that is non-addictive, regulatory strategies to ensure compliance with an established standard, how a low-nicotine standard should work with other nicotine products in a well-regulated nicotine market.

Testimony heard by your Reference Committee was mostly supportive of Resolution 431. It was noted that the Food and Drug Administration will be looking at this issue and therefore it is timely for the AMA to review the available evidence regarding selection of a nicotine standard that is non-addictive. Your Reference Committee agrees that this is a timely issue to study and therefore recommends referral.

(35) RESOLUTION 419 - VIOLENCE PREVENTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 419 be referred for decision.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 419 not be adopted.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 419 be referred.

Resolution 419 asks that our American Medical Association: (1) advocate that a valid permit be required before the sale of all rapidly-firing semi-automatic firearms; (2) study options for removing access to firearms for those who may be a threat to themselves or others; (3) study options for improving the mental health reporting systems and patient privacy laws at both the state and federal levels and how those can be modified to allow greater information sharing between state and federal government, law enforcement, schools and mental health professionals to identify, track and share information about mentally ill persons with high risk of violence and either report to law enforcement and/or the National Instant Criminal Background Check System, with appropriate protections.

Your Reference Committee heard strong testimony in support of Resolution 419. However, it was noted in testimony by the Council on Legislation that the first Resolve overlapped with items of business being considered simultaneously in Reference Committee B. To ensure consistency between the recommendations of the Reference Committees, it was recommended that Reference Committee D refer the first Resolve for decision. Your Reference Committee agrees. The second Resolve is addressed by Council on Science and Public Health Report 4. For that reason, your Reference Committee recommends that it not be adopted. Your Reference committee agrees that the third Resolve, which addresses mental health issues, is worthy of study, but felt that due to the complex language of the resolve statement that it was best to refer it for study.

(36) RESOLUTION 433 - FIREARM SAFETY

RECOMMENDATION :

Madam Speaker, your Reference Committee recommends that Resolution 433 be referred for decision.

Resolution 433 asks that our American Medical Association adopt the following firearm safety policies:
1. Amend Policy H-145.993, “Restriction of Assault Weapons,” by addition to read as follows: Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the American public of all assault-type weapons, bump stocks and related devices, high capacity magazines of more than 10 bullets, and high-velocity and armor piercing bullets.

2. Require the licensing of owners of firearms including completion of a required safety course and registration of all firearms.

3. Support local law enforcement in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding “concealed carry”, by supporting “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and by supporting “red-flag” laws for individuals who have demonstrated significant signs of potential violence. In supporting local law enforcement, we support as well as the importance of “due process” so that decisions could be reversible by individuals petitioning in court for their rights to be restored.

Your Reference Committee heard testimony in strong support of the concepts in Resolution 433. The Council on Legislation testified that due to resolutions in Reference Committee B addressing assault weapons, bump stocks, and high capacity magazines, the Reference Committee should consider referring the first clause to the Board of Trustees for decision to ensure consistency in policy. Your Reference Committee heard strong support for licensing programs for firearms. The concepts of the third clause are addressed in Council on Science and Public Health Report 4. It was noted that the Council’s recommendations did not address the removal of firearms from convicted stalkers. Your Reference Committee agrees that this is an important provision and has

thus amended the Council's recommendations accordingly. Since this resolution contains one single resolve statement, your Reference Committee cannot separate the statements, and therefore referral for decision was deemed appropriate.

(37) RESOLUTION 420 - MANDATORY INFLUENZA VACCINATION POLICIES FOR HEALTHCARE WORKERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 420 not be adopted.

Resolution 420 asks that our American Medical Association enact as policy that no health care worker should be terminated from employment due solely to their refusal to be vaccinated for influenza.

Your Reference Committee heard both support and opposition for Resolution 420. The testimony in opposition to Resolution 420 noted that this resolution is contradictory to existing American Medical Association policies on influenza vaccination. The testimony in support of this resolution also suggested adding in the requirement of unvaccinated health care employees to wear a mask. Testimony also noted that a reasonable surveillance program for those who are unvaccinated is needed so we can ensure that we are protecting patients. Therefore, your Reference Committee recommends that Resolution 420 not be adopted.

(38) RESOLUTION 403 - SCHOOL SAFETY AND MENTAL HEALTH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-345.977 be reaffirmed in lieu of Resolution 403.

Resolution 403 asks that our American Medical Association promote the implementation of school-based mental health screening and therapy programs within its efforts to reduce school-based firearm violence.

Your Reference Committee heard supportive testimony on the issue of school-based mental health screening and therapy. AMA policy recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services. Your Reference Committee believes that current policy covers the intent of this resolution and therefore recommends that Policy H-345.977 be reaffirmed in lieu of this resolution.

Policy recommended for reaffirmation:

H-345.977 Improving Pediatric Mental Health Screening
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives. Res. 414, A-11, Appended: BOT Rep. 12, A-14.

Madam Speaker, this concludes the report of Reference Committee D. I would like to thank the fellow members of the committee Diana Ramos, MD, MPH, Cynthia Romero, MD, Ralph Schmeltz, MD, Victoria Sharp, MD, Michael DellaVecchia, MD, PhD; AMA staff members Andrea Garcia, Amber Ryan, and Amanda Coleman; and all those who testified before the Committee.

Diana Ramos, MD, MPH
American College of Obstetricians and Gynecologists

Victoria Sharp, MD
Iowa

Cynthia Romero, MD (Alternate)
Virginia

Michael DellaVecchia, MD, PhD
Pennsylvania

Ralph Schmeltz, MD
Pennsylvania

Shannon Kilgore, MD
American Academy of Neurology
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee E

Douglas Martin, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 10 – Over-the-Counter Contraceptive Drug Access (Resolution 110-A-17)
2. Board of Trustees Report 22 – In-Flight Emergencies (Resolution 516-A-17, Resolve 3)
3. Board of Trustees Report 29 – Support for Service Animals, Emotional Support Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership (Resolution 508-A-17)
4. Board of Trustees Report 30 – In-Flight Emergencies (Resolution 516-A-17, Resolve 5)
5. Council on Science and Public Health Report 3 – Providing for Prescription Drug Donation
6. Resolution 504 – Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex)
7. Resolution 514 – Effects of Virtual Reality on Human Health
8. Resolution 524 – Naloxone on Commercial Airlines
9. Resolution 526 – Direct-to-Consumer (DTC) Laboratory Testing

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

10. Resolution 502 – Expedited Prescription CBD Drug Rescheduling
    Resolution 509 – Opposing the Classification of Cannabidiol as a Schedule 1 Drug
11. Resolution 508 – Reintroduction of Mitochondrial Donation in the United States

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

12. Board of Trustees Report 38 – Timely Referral to Pain Management Specialist (Resolution 714-A-17)
13. Council on Science and Public Health Report 2 – Drug Shortages: Update
    Resolution 517 – Impact of Natural Disasters on Pharmaceutical Supply and Public Health
14. Resolution 506 – Non-Therapeutic Gene Therapies
15. Resolution 511 – Education for Recovering Patients on Opiate Use After Sobriety
16. Resolution 516 – Waste Incinerator Ban
17. Resolution 518 – Portable Listening Devices and Noise Induced Hearing Loss
18. Resolution 521 – EPA Glider Truck Standard
19. Resolution 523 – Biosimilar Interchangeability Pathway

RECOMMENDED FOR REFERRAL

20. Resolution 507 – Opioid Treatment Programs Reporting to Prescription Monitoring Programs
21. Resolution 515 – Information Regarding Animal-Derived Medications

RECOMMENDED FOR NOT ADOPTION

22. Resolution 505 – Researching Drug Facilitated Sexual Assault Testing
23. Resolution 513 – Hand Sanitizer Effectiveness
24. Resolution 522 – Silence Science: EPA Proposed Data Policy
25. Resolution 525 – Tramadol Change from DEA Schedule IV to Schedule III

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

26. Resolution 503 – Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians
27. Resolution 512 – Physician and Patient Education About the Risk of Synthetic Cannabinoid Use

Resolutions handled via the Reaffirmation Consent Calendar:

Resolution 501 – Synthetic Cannabinoids
Resolution 510 – Alcohol Use and Cancer
Resolution 519 – Warning Labels for Children's Digital and Video Games
Resolution 520 – Handling of Hazardous Drugs

(1) BOARD OF TRUSTEES REPORT 10 – OVER-THE-COUNTER CONTRACEPTIVE DRUG ACCESS (RESOLUTION 110-A-17)

RECOMMENDATION:

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

Board of Trustees Report 10 is in response to Resolution 110-A-17 and discusses a variety of concerns that have been raised regarding over-the-counter (OTC) oral contraceptives, including barriers to access, cost of a potential OTC oral contraceptive, and safety. It also includes discussion of the existing FDA pathway for the conversion of prescription products, such as oral contraceptives, to OTC products if manufacturers submit the required application and data. The Board of Trustees recommends the following be adopted in lieu of Resolution 110-A-17, and the remainder of the report be filed:

1. That our AMA amend Policy D-75.995, "Over-the-Counter Access to Oral Contraceptives;"
   D-75.995, "Over-the-Counter Access to Oral Contraceptives"
   Our AMA:
   1. ~~Our AMA~~ Encourages ~~will recommend to the US Food and Drug Administration that~~ manufacturers of oral contraceptives ~~be encouraged~~ to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a switch in status from prescription to over-the-counter for such products.
   2. ~~Our AMA~~ Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives. (Modify HOD Policy)
2. That our AMA amend Policy H-180.958, "Coverage of Prescription Contraceptives by Insurance;"
   H-180.958, "Coverage of ~~Prescription~~ Contraceptives by Insurance"
   1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.
   2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care. (Modify HOD Policy)

Testimony was supportive of the Board's report and its inclusion of several issues related to a potential over-the-counter oral contraceptive product. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 10 be adopted.

(2) BOARD OF TRUSTEES REPORT 22 – IN-FLIGHT EMERGENCIES (RESOLUTION 516-A-17, RESOLVE 3)

RECOMMENDATION:

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

Board of Trustees Report 22, in response to Resolution 516-A-17, Resolve 3, outlines the current requirements concerning the verification of a medical professional's credentials in the event of an in-flight medical emergency (IFME) and existing AMA policies on physician identification of credentials and delivery of health care by Good Samaritans. The Board of Trustees recommends existing AMA Policy H-45.979, "Air Travel Safety," be reaffirmed in lieu of Resolve 3, Resolution 516-A-17, and the remainder of the report be filed. (Reaffirm Current HOD Policy)

The Board of Trustees was thanked for developing this report. Your Reference Committee heard testimony in support of the report's recommendations, and in line with reaffirmation of existing AMA Policy H-45.979. Therefore, your Reference Committee urges adoption of the report's recommendation.

Policy recommended for reaffirmation:

H-45.979, "Air Travel Safety"
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar. CSA Rep. 5, I-98 Appended: CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Appended: Res. 718, A-14 Reaffirmation I-14 Reaffirmed in lieu of Res. 503, A-15 Reaffirmed in lieu of: Res. 502, A-16 Reaffirmed in lieu of: Res. 516, A-17

(3) BOARD OF TRUSTEES REPORT 29 – SUPPORT FOR SERVICE ANIMALS, EMOTIONAL SUPPORT ANIMALS, ANIMALS IN HEALTHCARE, AND MEDICAL BENEFITS OF PET OWNERSHIP (RESOLUTION 508-A-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 29 be adopted and the remainder of the report be filed.

Board of Trustees Report 29 is in response to Resolution 508-A-17. Considerable confusion exists in differentiating service animals, emotional support animals (ESAs), and companion animals as well as the role of animals in animal-assisted therapy (AAT). This report defines the different categories of assistance animals and outlines the current landscape of evidence related to the use of animals in medical treatments. The Board of Trustees recommends the following policy be adopted in lieu of Resolution 508-A-17, and the remainder of the report be filed:

Service Animals, Animal-Assisted Therapy, and Animals in Healthcare
Our American Medical Association:

1. Encourages research into the use of animal-assisted therapy as a part of a therapeutic treatment plan.
2. Supports public education efforts on legitimately trained service animals, as defined by the Americans with Disabilities Act (ADA).
3. Supports a national certification program and registry for legitimately trained service animals, as defined by the ADA.
4. Encourages health care facilities to set evidence-based policy guidelines for animal visitation. (New HOD Policy)

Testimony commended the clarity this report provided regarding the various classifications of animals used in healthcare and for the treatment of various conditions. Commenters were unanimously supportive of the recommendations in the report. Additionally, an amendment was offered, but due to insufficient evidence regarding the amendment, your reference Committee does not believe it is appropriate. Therefore, your Reference Committee recommends that Board of Trustees Report 29 be adopted.

(4) BOARD OF TRUSTEES REPORT 30 – IN-FLIGHT EMERGENCIES (RESOLUTION 516-A-17, RESOLVE 5)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 30 be adopted and the remainder of the report be filed.

Board of Trustees Report 30, in response to Resolution 516-A-17, Resolve 5, outlines the current options for physician continuing medical education (CME), guidance, and policy on the topic of in-flight medical emergencies (IFMEs). The Board of Trustees recommends the existing AMA Policy H-45.979, “Air Travel Safety,” be reaffirmed in lieu

of Resolve 5, Resolution 516-A-17, and the remainder of the report be filed. (Reaffirm Current HOD Policy)

Your Reference Committee heard testimony regarding anecdotal experiences related to IFMEs and the need to ensure that onboard medical supplies are appropriate for treating the most common emergencies. Several individuals and organizations, such as AsMA, commented that the report concisely listed resources for physician education related to IFMEs. Overall, the majority of testimony supported the report and its recommendations. Therefore, your Reference Committee recommends that Board of Trustees Report 30 recommendations be adopted and the remainder of the report filed.

Policy recommended for reaffirmation:

H-45.979, "Air Travel Safety"
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar. CSA Rep. 5, I-98 Appended: CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Appended: Res. 718, A-14 Reaffirmation I-14 Reaffirmed in lieu of Res. 503, A-15 Reaffirmed in lieu of: Res. 502, A-16 Reaffirmed in lieu of: Res. 516, A-17

(5) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – PROVIDING FOR PRESCRIPTION DRUG DONATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 3 be adopted and the remainder of the report be filed.

Council on Science and Public Health Report 3 is in response to Resolution 207-I-17 and Resolution 525-A-17. Both of the resolutions reflect concerns about the intersection of rising drug costs, wastage and expiration of unused pharmaceutical products prompting their disposal, and existing problems with patient access and their ability to pay for needed therapies. The focus of this report is the recycling and re-dispensing of unused medications and authorized drug repository and/or return and reuse programs for prescription medications in states. The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 207-I-17 and Resolution 525-A-17 and the remainder of the report be filed:

Our AMA encourages:

1. States with laws establishing prescription drug repository and/or "return and reuse" programs to implement such laws and to consider integrating them with existing recycling or disposal programs. (New AMA Policy)
2. States that lack drug repository and/or "return and reuse" programs to enact such laws in consultation with their state board of pharmacy. (New AMA Policy).
3. State medical associations in states where there is a prescription drug repository or a "return and reuse" program for unused medication supplies to educate physicians in their state regarding the existence of such programs. (New HOD Policy).

Limited but broadly supportive testimony was offered on this report. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 3 be adopted.

(6) RESOLUTION 504 – ENDING THE RISK EVALUATION AND MITIGATION STRATEGY (REMS) POLICY ON MIFEPRISTONE (MIFEPREX)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 504 be adopted.

Resolution 504 asks that the American Medical Association support efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone. (New HOD Policy)

Limited but supportive testimony was heard to eliminate the current REMS program for mifepristone, including from the American Congress of Obstetricians and Gynecologists. In 2016, the label for mifepristone was updated to reflect contemporary, and more effective dosing practices. Testimony further supported a long history of safe mifepristone use, low rates of serious adverse events, and a mortality rate that is 14 times less than pregnancy-related death. Eliminating the mifepristone REMS also was noted as a way to increase access to this treatment. Your Reference Committee recommends that Resolution 504 be adopted.

(7) RESOLUTION 514 – EFFECTS OF VIRTUAL REALITY ON HUMAN HEALTH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 514 be adopted.

Resolution 514 asks that our American Medical Association supports further study on the impact of virtual reality on human health. (New HOD Policy)

Your Reference Committee heard testimony supportive of this resolution, including the scope of anticipated risks and need for additional research to examine potential for

harmful effects of this emerging technology. Therefore, your Reference Committee recommends that Resolution 514 be adopted.

(8) RESOLUTION 524 – NALOXONE ON COMMERCIAL AIRLINES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 524 be adopted.

Resolution 524 asks that the American Medical Association supports the addition of naloxone to the airline medical kit, that the AMA encourage airlines to voluntarily include naloxone in their airline medical kits, and that the AMA encourage the addition of naloxone to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits). (New HOD Policy)

Your Reference Committee heard testimony strongly in support of this resolution. Access to naloxone should be broad. Therefore, your Reference Committee recommends that Resolution 524 be adopted.

(9) RESOLUTION 526 – DIRECT-TO-CONSUMER (DTC) LABORATORY TESTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 526 be adopted.

Resolution 526 asks that our American Medical Association: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional. (Directive to Take Action)

Your Reference Committee heard testimony supportive of the proposed resolution, which mentioned a need for increasing oversight of DTC testing by federal agencies, and encouraging communication of risks of DTC tests by physicians. Therefore, your Reference Committee recommends that Resolution 526 be adopted.

(10) RESOLUTION 502 – EXPEDITED PRESCRIPTION CBD DRUG RESCHEDULING

RESOLUTION 509 – OPPOSING THE CLASSIFICATION OF CANNABIDIOL AS A SCHEDULE 1 DRUG

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Resolution 502 be adopted in lieu of Resolution 509.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 506 be changed to read as follows:

EXPEDITED PRESCRIPTION CANNABIDIOL (CBD) DRUG RESCHEDULING

Resolution 502 asks that our American Medical Association (AMA) encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration and that our AMA advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products. (New HOD Policy)

Resolution 509 asks that our American Medical Association support the reclassification of Cannabidiol (CBD) as a non-scheduled drug. (New HOD Policy)

Your Reference Committee heard significant testimony in support of Resolution 502. Many testified in support of steps to assure that prescription medications that have been studied in randomized controlled trials and evaluated by the FDA should not be classified as schedule 1 drugs. An FDA approved medication should be accessible by patients and dispensable by pharmacies. Strong opposition to Resolution 509 was noted; reclassifying all cannabidiol products to be non-scheduled is too broad, and it is only appropriate to reclassify FDA approved products. Your Reference Committee agrees and recommends that Resolution 502 be adopted in lieu of resolution 509.

(11) RESOLUTION 508 – REINTRODUCTION OF MITOCHONDRIAL DONATION IN THE UNITED STATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 508 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 508 be changed to read as follows:

MITOCHONDRIAL DONATION

Resolution 508 asks that our American Medical Association support regulated research to determine the efficacy and safety of mitochondrial donation as a means of preventing the transmission of mitochondrial diseases. (New HOD Policy)

Testimony was provided in support of this resolution encouraging regulated research for mitochondrial donation. Therefore, your Reference Committee recommends that Resolution 508 be adopted, with a change in title to more accurately reflect describe the policy.

(12) BOARD OF TRUSTEES REPORT 38 – TIMELY REFERRAL TO PAIN MANAGEMENT SPECIALIST (RESOLUTION 714-A-17)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 38 be amended by addition and deletion to read as follows:

The Board of Trustees recommends that Policy H-185.931 be amended by addition and deletion in lieu of Resolution 714-A-17 and the remainder of the report be filed:

Policy H-185.931, "Workforce and Coverage for ~~Chronic~~ Pain Management"
1. Our American Medical Association (AMA) supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.

2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.

~~1.~~3. Our American Medical Association (AMA) 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.~~4. 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.~~5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within mutildisciplinary pain clinics.~~which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve~~ P~~p~~atients and their caregivers should be involved in the decision-making process.
(Modify Current HOD Policy)

6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.

Board of Trustees Report 38 is in response to Resolution 714-A-17. This report discusses whether the AMA should urge CMS to adopt clinical practice guidelines on the management and treatment of pain. The Board of Trustees recommends that Policy H-185.931 be amended by addition and deletion in lieu of Resolution 714-A-17 and the remainder of the report be filed:

H-185.931, "Coverage for Pain Management"

1. Our American Medical Association (AMA) supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options when appropriate, with a focus on achieving improvement in function and activities of daily living.

2. Guidance on pain management for different clinical indications should be developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.

~~1.~~3. Our ~~American Medical Association (~~AMA~~)~~ 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.~~4. 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.~~5. 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. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 38 be adopted as amended and the remainder of the report be filed.

Your Reference Committee heard Testimony highly supportive of the Board of Trustees recommendations to amend current policy. This testimony reflected both the need for physician autonomy with respect to pain management and also referral for specialty care when appropriate. Amendments were offered that were positive additions to expand the policy to include interventional approaches and expanded availability of comprehensive multidisciplinary centers; further testimony was in agreement. Your Reference Committee concurs that the amended policy is an appropriate response and therefore recommends adoption as amended.

(13) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – DRUG SHORTAGES: UPDATE

RESOLUTION 517 – IMPACT OF NATURAL DISASTERS ON PHARMACEUTICAL SUPPLY AND PUBLIC HEALTH

RECOMMENDATION A:

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

The CSAPH recommends that Policy H-100.956 be amended by addition and deletion to read as follows:
H-100.956, “National Drug Shortages”

1. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply ~~experience drug shortages~~, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services

(DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

3. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
5. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.
6. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
8. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
9. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical

manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

10. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages.
11. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
12. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
13. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
14. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 2 be adopted as amended in lieu of Resolution 517 and the remainder of the report be filed.

Council on Science and Public Health Report 2 is in response to policy H-100.956, which directs the Council to continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages in the U.S. This ninth report in the series updates information on drug shortages since the 2017 report was developed, specifically commenting on the increase in drug shortages due to hurricanes that have impacted the pharmaceutical industry in Puerto Rico as well as other relevant policy considerations regarding manufacturer processes recently brought to light which have implications for the United States health care system. The Council on Science and Public Health recommends that Policy H-100.956 be amended by addition and deletion to read as follows:

H-100.956, "National Drug Shortages"

1. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply ~~experience drug shortages~~, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

2. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
3. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
5. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.
6. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
8. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
9. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
10. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages.
11. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
12. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
13. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

14. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. (Modify Current HOD Policy)

Resolution 517 asks that our American Medical Association (AMA) study the impact of natural disasters on the pharmaceutical supply chain and downstream effects on patient care, as well as the adequacy of our governmental response to mitigating these recent natural disasters; (Direction to Take Action) and that our American Medical Association amend policy H-100.956 by addition as follows:

National Drug Shortages H-100.956

1. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that experience drug shortages, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
3. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
5. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The Centers for Medicare & Medicaid Services should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.
6. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

8. Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
9. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. (Modify Current HOD Policy)

Testimony was overwhelmingly supportive of the Council's report and recommendations, as well as the recommendation contained in the second Resolve of Resolution 517 to amend the drug shortages Policy. Significant discussion revolved around the major impact shortages are having on patient care and delivery. This current report from the Council covers the topic of natural disasters and the ability of the government to respond in such situations, as was recommended in Resolve 1 of Resolution 517. The report made recommendations regarding critical infrastructure to give the government, as well as drug manufacturers, better ability to recover after natural disasters. Your Reference Committee believes that the amendment offered to number 4 of the CSAPH recommendation adequately addresses Resolution 517, Resolve 2. Therefore, your Reference Committee recommends adoption of CSAPH Report 2 as amended in lieu of Resolution 517.

(14) RESOLUTION 506 – NON-THERAPEUTIC GENE THERAPIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 506 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~partners with relevant institutions to~~ encourages the development of safety guidelines~~,~~ and regulations~~, and permissible uses of~~ regarding performance enhancing, non-therapeutic gene therapies.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 506 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 506 be changed to read as follows:

GENE DOPING

Resolution 506 asks that our American Medical Association partners with relevant institutions to encourage the development of safety guidelines, regulations, and permissible uses of performance enhancing, non-therapeutic gene therapies. (Directive to Take Action)

Your Reference Committee heard testimony generally in support of this Resolution. However, it was noted by many, including the Council on Science and Public Health, that other organizations are in a better position to lead this effort. Testimony also noted the ethical opinion that gene-therapy should only be a therapeutic treatment and questioned the inclusion of "permissible uses." Therefore, your Reference Committee recommends that Resolution 506 be adopted as amended with a change in title to more accurately reflect the policy.

(15) RESOLUTION 511 – EDUCATION FOR RECOVERING PATIENTS ON OPIATE USE AFTER SOBRIETY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 511 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association (AMA) amend Policy D-95-987 by addition to read as follows
D-95.987, "Prevention of Opioid Overdose"
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.
3. <u>Our AMA support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death. (Modify Current HOD Policy)</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 511 be adopted as amended.

Resolution 511 asks that our American Medical Association (AMA) amend Policy D-95-987 by addition to read as follows:

Prevention of Opioid Overdose D-95.987

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.
3. That our AMA implement an appropriate education program for recovering opioid abuse patients and their friends/families that opioid use after significant sobriety time can result in overdose and death. (Modify Current HOD Policy)

Testimony affirmed that individuals who previously misused prescription or illicit opioids, and who developed physical dependence and/or opioid use disorder, are at increased risk of overdose after a period of sobriety. This includes those who have been incarcerated. While there was affirmation of the need to address this specific risk, an amendment was offered for the AMA to support the development of education from those who are experts in this area because skepticism was expressed about the ability of the AMA to reach the intended audience. Therefore, your Reference Committee recommends that Resolution 511 be adopted as amended.

(16) RESOLUTION 516 – WASTE INCINERATOR BAN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 516 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) amend Policy H-135.939 as follows:

Green Initiatives and the Health Care Community H-135.939

Our AMA supports ~~and shall prioritize~~: (1) responsible waste management and clean energy production policies that ~~do not pose~~ minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities; (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 516 be amended by deletion as follows:

~~RESOLVED, That our AMA request and actively advocate for national legislation that bans waste incinerators in our nation due to their adverse health effects, negative environmental impact, and lack of cost effectiveness. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 516 be adopted as amended.

Resolution 516 asks that our American Medical Association (AMA) amend policy H-135.939 as follows:

Green Initiatives and the Health Care Community H-135.939

Our AMA supports and shall prioritize: (1) responsible waste management and clean energy production policies that do not pose health risks, including the

promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities; (Modify Current HOD Policy)

And that our AMA request and actively advocate for national legislation that bans waste incinerators in our nation due to their adverse health effects, negative environmental impact, and lack of cost effectiveness. (Directive to Take Action)

Reference Committee heard testimony supportive of Resolution 516. Testimony focused on possible health hazards from waste incinerators, and supported alternatives to waste incinerators that might be anticipated to represent safer and more economical waste management, as well as more sustainable practices. It was also noted that our AMA has existing policy that supports clean energy production. The second Resolve of Resolution 516 asked that our AMA ban waste incinerators by amending existing policy. However, the evidence presented is insufficient to support a substantial change in the AMA's policy on waste incinerators. Therefore, your Reference Committee recommends that the Resolution 516 be adopted as amended.

(17) RESOLUTION 518 – PORTABLE LISTENING DEVICES AND NOISE INDUCED HEARING LOSS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-440.957 be <u>amended by addition and deletion</u> to read as follows:

H-440.957, "Reporting Potential for Hearing Loss Due to Personal Listening Devices"
It is the policy of the AMA that (1) physicians counsel patients about the potential loss of hearing associated with the misuse of personal listening devices; (2) research be directed at more specific definition of the relationship between acute and chronic use of personal listening devices and the occurrence of short-term and long-term noise-induced hearing loss; ~~and~~ (3) the AMA work with the National Institute on Deafness and Other Communication Disorders to enhance awareness, knowledge and remediation of causes of noise induced hearing loss~~.~~<u>; and (4) portable listening devices limit the maximum sound amplitude to safe levels.</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-440.957 be <u>adopted as amended in lieu of Resolution 518</u>.

Resolution 518 asks that our American Medical Association (AMA) update its policy on portable listening devices to support the use of Portable listening devices that limit the maximum sound amplitude to safe levels and that our AMA advocate on a federal level for labeling on earbuds that do not have amplitude limiters to warn of the risk of hearing loss with extended use at high volume levels for extended periods as described in the CSAPH Report 6-A-08. (New HOD Policy)

Your Reference Committee heard largely supportive testimony on this issue. Although the Council on Science and Public Health (CSAPH) commented that current policy based on CSAPH report A-08 is still relevant, other testimony commented that a subset of new devices may be an issue. However, because of uncertainty regarding the evidence, your Reference Committee believes that amending current policy to reflect the first Resolve is appropriate. However, because of the lack of evidence noted by CSAPH, your Reference Committee feels that actively advocating for labeling is not warranted or appropriate for the AMA to pursue at this time. Therefore, your Reference Committee recommends that Policy H-440.957 be amended in lieu of Resolution 518.

(18) RESOLUTION 521 –EPA GLIDER TRUCK STANDARD

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-135.996 be amended by addition and deletion to read as follows:

D-135.996, “Reducing Sources of Diesel Exhaust”
Our AMA will: (1) encourage the US Environmental Protection Agency to finalize the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats, ~~and~~ trains, and glider trucks; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from existing diesel; and (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with new diesel emissions standards promulgated by US EPA. Res. 428, A-04 Reaffirmed in lieu of Res. 507, A-09 Reaffirmation A-11 Reaffirmation A-14

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy D-135.996 be adopted as amended in lieu of Resolution 521.

Resolution 521 asks that our American Medical Association send a letter to U.S. Environmental Protection Agency (EPA) Administrator opposing the EPA’s proposal to roll back the “Glider Kit Rule” which would effectively allow the unlimited sale of re-

conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony of Resolution 521, especially as it relates to the public health impacts of diesel truck engines. After reviewing Policy D-135.996, your Reference Committee concluded that the addition of "glider trucks" to part one of the Policy would maintain the intent of Resolution 521. Therefore, your Reference Committee recommends that Policy D-135.996 be reaffirmed as amended in lieu of Resolution 521.

(19) RESOLUTION 523 – BIOSIMILAR INTERCHANGEABILITY PATHWAY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 523 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association strongly support the ~~rigorous~~ pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug (New HOD Policy); and be it further

RESOLVED, That our AMA issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance "Considerations in Demonstrating Interchangeability With a Reference Product" with all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 523 be adopted as amended.

Resolution 523 asks that our American Medical Association strongly support the rigorous pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug (New HOD Policy) and that our AMA issue a request to the FDA that the agency finalize the

biosimilars interchangeability pathway outlined in its draft guidance "Considerations in Demonstrating Interchangeability With a Reference Product" with all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients. (Directive to Take Action)

Your Reference Committee heard strongly supportive testimony around the need to develop a vibrant biosimilar pathway, including development of standards for manufacturers to seek approval of a biosimilar as interchangeable. While biosimilars are widely viewed as having significant cost-savings potential, the extent of realized savings will be variable. The FDA strongly agreed with the need for further maturation of the biosimilar approval pathway and indicated their intention to finalize guidance on considerations in demonstrating interchangeability with a reference product by May 2019. Adoption of Resolution 523 as amended is recommended.

(20) RESOLUTION 507 – OPIOID TREATMENT PROGRAMS REPORTING TO PRESCRIPTION MONITORING PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 507 be <u>referred</u>.

Resolution 507 asks that our American Medical Association (AMA) amend the policy Opioid Treatment and Prescription Drug Monitoring Programs D-95.980 by deletion as follows:

> That our AMA will seek changes to ~~allow states the flexibility to~~ require opioid treatment programs to report to prescription monitoring programs. (Modify Current HOD Policy)

Divided and polarizing testimony was offered on this resolution. Those opposing Opioid Treatment Programs (OTPs) reporting to Prescription Drug Monitoring Programs (PDMPs) cited concerns about privacy and confidentiality, the stigma that already exists around individuals being treated for opioid use disorder and the likelihood that opening PDMPs up to OTP reporting would have a substantial chilling effect on the willingness of patients to enter into treatment. Evidence supporting this view includes the fact that more than 20 state PDMPs are either under the control of, or easily accessible by law enforcement. Additionally, testimony noted that Resolution 507 conflicts with current federal law (42 CFR Part 2) as it pertains to the structure, function, and reporting requirements of OTPs. Given the nature and extent of the current opioid epidemic, supporters of mandatory reporting by OTPs noted the importance of understanding a patient's controlled substance prescription history in order to inform appropriate clinical decision-making. This opinion views PDMPs as clinical decision support tools.

Current AMA Policy H-95.946 supports the view that PDMPs should be clinical decision support tools, and in addition, encourages all state agencies responsible for maintaining and managing a PDMP to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system. Our AMA also holds that strong confidentiality safeguards and protections of state databases must

be in place to limit access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred. Policy H-95.947 supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information. Policy H-315.965 supports: (1) regulatory and legislative changes that better balance patients' privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.

This is a complicated subject with far reaching ramifications and overlapping AMA policies. Your Reference Committee believes referral is required to adequately address this important issue.

(21) RESOLUTION 515 – INFORMATION REGARDING ANIMAL-DERIVED MEDICATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 515 be referred.

Resolution 515 asks that our American Medical Association (AMA) supports efforts to improve cultural awareness pertaining to the use of animal-derived medications when considering different prescription options and (New HOD Policy) and that our AMA encourage the U.S. Food and Drug Administration to make available to the public an easily accessible database that identifies medications containing ingredients derived from animals. (Directive to Take Action)

Limited testimony was offered on this resolution. It is known that certain chemical products used as additives or stabilizers for prescription drugs are derived from animal sources. The consumption of such products may be objectionable to certain religions or based on consumer choice. Testimony from the U.S. Food and Drug Administration agreed with the validity of this view, but noted the potential complexity of establishing registries for individual drug formulations that might be "culturally competent." Therefore, your Reference Committee recommends that Resolution 515 be referred.

(22) RESOLUTION 505 – RESEARCHING DRUG FACILITATED SEXUAL ASSAULT TESTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 505 not be adopted.

Resolution 505 asks that our American Medical Association study the feasibility and implications of offering drug testing at point of care for date rape drugs, including

rohypnol, ketamine, and gamma-hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault. (Directive to Take Action)

Supportive testimony was offered on the intent of this Resolution. However, several dissenting points were raised including concerns about chain of custody of evidence required for legal proceedings, specific responsibilities of the treating physician, relevant jurisdictions for obtaining and preserving evidence, and the fact that the point-of-care (POC) tests referred to in the resolution will not provide useful results in this setting. Many urine drug tests (UDTs) utilized in clinical care are grounded in immunoassay (IA) technology. IA UDTs are designed to detect a specific drug or a class of drugs as either present or absent based on a designated threshold cut-off concentration. Results based on IAs are considered presumptive and are often used as an initial screening test (i.e., qualitatively positive or negative) in clinical UDT. POC tests are typically non-instrumented IA devices (strips, dipcards) that can be used in clinics and are presumptive, qualitative, variable, and have a number of other limitations. Several of the drugs mentioned in the Resolution, and other related substances that have been implicated in drug facilitated sexual assault cannot be tested for using a POC device. Your Reference Committee does not believe that POC testing in drug facilitated sexual assault is worthy of further study at this point and recommends that Resolution 505 not be adopted.

(23) RESOLUTION 513 – HAND SANITIZER EFFECTIVENESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 513 not be adopted.

Resolution 513 asks that our American Medical Association urge the U.S. Food and Drug Administration and the Centers for Disease Control and Prevention to continue to study the use of hand sanitizers in clinical settings, including the risks and benefits to patients and health care professionals. (Directive to Take Action)

Your Reference Committee heard divided testimony regarding this issue. Although the intent was supported by some testimony, the FDA provided comment in opposition because they are already taking significant action on the use of hand sanitizers and the ingredients used in hand sanitizer products. FDA also commented that the task of evaluating hand sanitizers is their task, not the purview of the CDC. Because this work is underway at the FDA, your Reference Committee recommends that Resolution 513 not be adopted.

(24) RESOLUTION 522 – SILENCE SCIENCE: EPA PROPOSED DATA POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 522 not be adopted.

Resolution 522 asks that Our American Medical Association (AMA) submit comments during the public comment period, or join comments written by other medical organizations, to express concern with the U.S. Environmental Protection Agency's (EPA) proposal to limit the use of research studies published in peer reviewed scientific journals that describe the adverse health effects of exposure to air pollution and other environmental exposures and that our AMA reaffirm the value and integrity of the journal peer review process by sending a letter to the EPA stating that studies that have been published in scientific peer reviewed journals should be used by the agency in informing EPA regulatory policy making. (Directive to Take Action)

Your Reference Committee heard testimony generally in support of this Resolution. Testimony did state that several organizations, including medical groups, academicians, and industry, have already individually or jointly submitted comments to the EPA requesting an extension to the 30-day comment period regarding the proposal mentioned in the Resolution. Testimony noted the AMA signed on to a letter written by the American Thoracic Society (ATS) requesting a 60-day extension to the comment period. On May 24th, EPA extended the deadline and scheduled a public hearing on the proposed rule for July 17th. The AMA does intend to submit comments regarding the proposed rule, either by joining a Federation Member's letter or developing comments. Because response to this resolution is underway, your Reference Committee recommends that Resolution 522 not be adopted.

(25) RESOLUTION 525 – TRAMADOL CHANGE FROM DEA SCHEDULE IV TO SCHEDULE III

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 525 be <u>not be adopted.</u>

Resolution 525 asks that the American Medical Association petition the United States Drug Enforcement Administration to change tramadol from a Schedule IV to a Schedule III controlled substance. (Directive to Take Action)

Your Reference Committee heard testimony generally opposing review of the current schedule of tramadol. It was pointed out that changing from a schedule IV to a schedule III controlled substance would not significantly change the control measures of the drug since prescribing standards are the same for schedule III and IV substance. Additionally, it was noted that to change the schedule of a drug, the DEA would be required to review currently available evidence to determine the appropriate schedule for the drug. Your Reference Committee agrees with testimony that supports retaining the schedule of tramadol by the DEA and therefore recommends that Resolution 525 not be adopted.

(26) RESOLUTION 503 – ADVOCATING FOR ANONYMOUS REPORTING OF OVERDOSES BY FIRST RESPONDERS AND EMERGENCY PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-95.940 be reaffirmed in lieu of Resolution 503.

Resolution 503 asks that our American Medical Association support non-fatal and fatal opioid overdose reporting to the appropriate agencies. (New HOD Policy)

Your Reference Committee heard testimony generally in support of Resolution 503. However, ambiguity around maintaining patient and physician anonymity was noted, as well as specifications on which agencies are considered appropriate for notification.

Your Reference Committee supported the intent of the resolution, but, after reviewing policy H-95.940 parts three and four, concluded that existing policy limited ambiguity noted during testimony by supporting ongoing efforts to continuously monitor trends in illicit drug use, taking a multi-stakeholder approach to addressing the issue while ensuring that all information gained through these collaborative measures be actionable and timely. Therefore, your Reference Committee recommends that Policy H-95.940 be reaffirmed in lieu of Resolution 503.

Policy recommended for reaffirmation:

H-95.940, “Addressing Emerging Trends in Illicit Drug Use”
Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4) encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. Sub. Res. 901, I-14 Modified: CSAPH Rep. 02, A-17

(27) RESOLUTION 512 – PHYSICIAN AND PATIENT EDUCATION ABOUT THE RISK OF SYNTHETIC CANNABINOID USE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-95.940 and D-95.970 be reaffirmed in lieu of Resolution 512.

Resolution 512 asks that our American Medical Association (AMA) encourage all physicians to become aware of the adverse psychiatric and medical effects, including coagulopathy with severe bleeding, related to the use of synthetic cannabinoids, which may or may not be contaminated and that our AMA encourage physicians to educate their patients about synthetic cannabinoids and strongly advise them that the use of these drugs carries significant health risks that can produce psychiatric morbidity and hematological mortality. (New HOD Policy)

Your Reference Committee heard testimony in strong support of this Resolution. The Council on Science and Public Health offered comments regarding their Report 2 from A-17 that addressed this issue and the resulting policy that addresses this topic. Therefore, your Reference Committee recommends that Policies H-95.940 and D-95.970 be reaffirmed in lieu of Resolution 512.

Policies recommended for reaffirmation:

H-95.940, “Addressing Emerging Trends in Illicit Drug Use”
Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4) encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. Sub. Res. 901, I-14 Modified: CSAPH Rep. 02, A-17

D-95.970, “Emerging Drugs of Abuse are a Public Health Threat”
Our AMA will participate as a stakeholder in a Centers for Disease Control and Prevention/U.S. Drug Enforcement Administration (CDC/DEA) taskforce for the development of a national forum for discussion of new psychoactive substances (NPS)-related issues. CSAPH Rep. 02, A-17

Madam Speaker, this concludes the report of Reference Committee E. I would like to thank Allan Anderson, MD, Jessica Cho, MD, Robert H. Emmick, MD, Jean Elizabeth Forsberg, MD, J. Leonard Lichtenfeld, MD, and all those who testified before the Committee as well as our AMA staff.

Allan Anderson, MD
American Association for Geriatric Psychiatry

Jean Elizabeth Forsberg, MD (Alternate)
College of American Pathologists

Jessica Cho, MD (Alternate)
Sectional Resident and Fellow

J. Leonard Lichtenfeld, MD
American College of Physicians

Robert H. Emmick, MD (Alternate)
Texas

Douglas Martin, MD
International Academy of Independent Medical Evaluators
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee F

Julia V. Johnson, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 – AMA 2019 Dues

2. Board of Trustees Report 35 – Model Hospital Medical Staff Bylaws

3. Board of Trustees Report 43 – American Podiatric Medical Association Request for Official Observer Status in the House of Delegates

4. Report of the House of Delegates Committee on the Compensation of the Officers

5. Resolution 601 – Creation of LGBTQ Health Specialty Section Council

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

6. Board of Trustees Report 20 – Anti-Harassment Policy

7. Board of Trustees Report 33 – Plan for Continued Progress toward Health Equity

8. Board of Trustees Report 34 – AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies
   Resolution 608 – Divestment from Companies Whose Primary Business is Fossil Fuel

9. Resolution 602 – Health Fitness Partnerships

10. Resolution 603 – Eliminating Food Waste Through Recovery

RECOMMENDED FOR REFERRAL

11. Resolution 604 – AMA Delegation Entitlements

12. Resolution 606 – Training Physicians in the Art of Public Forum

13. Resolution 607 – Discounted / Waived CPT Fees as an AMA Member Benefit and for Membership Promotion

RECOMMENDED FOR NOT ADOPTION

14. Resolution 605 – Practicing Physician Declining Membership Analysis

RECOMMENDED FOR FILING

15. Board of Trustees Report 1 – Annual Report

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2019 DUES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 4 be adopted and the remainder of the Report be filed.

Board of Trustees Report 4 recommends no changes to our AMA membership dues levels for 2019. The Report further notes that our AMA last raised its dues in 1994.

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

No testimony was presented in response to Board of Trustees Report 4. Your Reference Committee wishes to draw attention to the stability of our AMA dues since 1994 when the last increase took place. Most importantly, the close of 2017 reflects the seventh consecutive year of overall membership growth.

(2) BOARD OF TRUSTEES REPORT 35 - MODEL HOSPITAL MEDICAL STAFF BYLAWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 35 be adopted and the remainder of the Report be filed.

Board of Trustees Report 35 comes in response to Resolution 609-A-17, which asks our AMA to: (1) develop model hospital medical staff bylaws that incorporate currently believed to be best practices, meet the requirements of the Medicare Conditions of Participation, hospital accreditation organizations with deeming authority, and state laws and regulations, including annotations to show the source of all legal, regulatory, and accreditation requirements; (2) post this resource on the AMA website, continuously updated and available on demand to medical staffs, medical staff offices, and medical society staff, and widely distributed as an adjunct to the next edition of the AMA Physician's Guide to Medical Staff Bylaws; and (3) ask the legal counsels of State Medical Societies to outline state specific restrictions of medical staff self-governance so that these may be posted on the AMA-OMSS website for use by all AMA members.

In this report, the Board of Trustees recommends that the following be adopted in lieu of Resolution 609-A-17, and the remainder of the report be filed:

1. That our AMA continue to update the Physician's Guide to Medical Staff Organization Bylaws to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations. (Directive to Take Action)

2. That our AMA develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians. (Directive to Take Action)

3. That our AMA pursue opportunities to improve the accessibility and usability of the content contained in the Physician's Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth. (Directive to Take Action)

Your Reference Committee received testimony favoring adoption of the Board of Trustees Report and your Reference Committee is appreciative of the thorough review that was undertaken in response to Resolution 609-A-17.

(3) BOARD OF TRUSTEES REPORT 43 – AMERICAN PODIATRIC MEDICAL ASSOCIATION REQUEST FOR OFFICIAL OBSERVER STATUS IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 43 be adopted and the remainder of the Report be filed.

Board of Trustees Report 43 recommends that the American Podiatric Medical Association be admitted as an Official Observer in the House of Delegates, and that the remainder of the report be filed.

Your Reference Committee received no testimony in response to granting Official Observer status to the American Podiatric Medical Association. Your Reference Committee supports the recommendation proffered by the Board of Trustees.

(4) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

The Report of the House of Delegates Committee on Compensation of the Officers recommends that the President, President-elect, Immediate Past President, Chair, and Chair-elect honoraria be increased by 4% effective July 1, 2018.

Having received no testimony in response to the introduction of the Report of the House of Delegates Committee on Compensation of the Officers, your Reference Committee extends its appreciation to the Committee for its thorough work on behalf of our House of Delegates, and your Reference Committee supports adoption of the compensation report.

(5) RESOLUTION 601 - CREATION OF LGBTQ HEALTH SPECIALTY SECTION COUNCIL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 601 be adopted.

Resolution 601 calls upon our AMA House of Delegates to establish a Specialty Section Council on LGBTQ Health.

Your Reference Committee noted that our AMA Advisory Committee on LGBTQ Issues is not requesting section status by way of this resolution. Rather, the LGBTQ community and their allies who are seated among the various members in our AMA House of Delegates are seeking a forum within which various like-minded entities and individuals can achieve consensus around subjects of mutual interest.

Testimony recognized that this constituency group includes a growing cross-section of medical specialties and is a rapidly evolving field of medicine. Your Reference Committee received overwhelmingly supportive testimony in response to Resolution 601. Thus, your Reference Committee recommends adoption.

(6) BOARD OF TRUSTEES REPORT 20 - ANTI-HARASSMENT POLICY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 20 be amended by addition and deletion to read as follows:

Consistent with approaches taken in the professional community and in keeping with existing AMA policy regarding harassment, the Board of Trustees recommends that Policy H-140.837, "Anti-Harassment Policy," be amended by deleting Section 2 thereof, in its entirety, that the following be adopted, and that the remainder of this report be filed:

1. Reporting a complaint of harassment

   Any persons who believe they have experienced or witnessed conduct ~~in the AMA House of Delegates~~ in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel**.**

   Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.

   Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations

   Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and

thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

If AMA Human Resources shall determine~~s~~ that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, ~~and~~ (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) ~~a three-member disciplinary committee comprised of the Chair of the Board of Trustees, the Immediate Past President of the AMA and the President-Elect of the AMA,~~ for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with a appropriate training. ~~and/or referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action.~~

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, ~~the disciplinary committee~~ CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, ~~the disciplinary committee~~ CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

   To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 20 be adopted as amended and the remainder of the Report be filed.

Board of Trustees Report 20 recommends procedures to implement fully Policy H-140.837, "Anti-Harassment Policy," with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC) and CPT Editorial Panel.

Consistent with approaches taken in the professional community and in keeping with existing AMA policy regarding harassment, the Board of Trustees recommends that Policy H-140.837, "Anti-Harassment Policy," be amended by deleting Section 2 thereof, in its entirety and that revised language be adopted with the remainder of the report being filed.

Testimony on Board of Trustees Report 20 was strongly supportive of the Board of Trustees' efforts to establish a comprehensive anti-harassment policy and procedures for our AMA's governance entities. Two amendments were offered and incorporated by your Reference Committee.

With respect to the disciplinary processes outlined in section three of the amended language, your Reference Committee believes that the establishment of a three-member disciplinary committee comprised of the Chair of the Board of Trustees, the Immediate Past President of the AMA, and the President-Elect of the AMA for disciplinary and/or corrective action is inadvisable due to potential conflicts of interest. For that reason, your Reference Committee recommends alternate language to eliminate this Committee and proceed directly to CEJA for final action as necessary. Recognizing that claims of harassment can be complicated and perhaps unfamiliar to CEJA, your Reference Committee has also included language that recommends CEJA receive appropriate training in evaluating harassment claims if necessary.

Your Reference Committee believes that adoption of this report as amended will contribute to the ongoing collegiality and professionalism that already exists at our AMA meetings and events.

(7) BOARD OF TRUSTEES REPORT 33 - PLAN FOR CONTINUED PROGRESS TOWARD HEALTH EQUITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 33 be amended by addition and deletion to read as follows:

The Board of Trustees recommends the following be adopted in lieu of Resolution 601-A-17 and the remainder of the report be filed:

1. That Health Equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care;~~,~~ increasing health workforce diversity;~~,~~ influencing determinants of health;~~,~~ and voicing and modeling commitment to health equity. **(**New HOD Policy**)**

2. That our AMA develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities. **(**Directive to Take Action**)**

3. That the Board provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements. (Directive to Take Action**)**

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 33 be adopted as amended and the remainder of the Report be filed.

Board of Trustees Report 33 comes in response to Resolution 601-A-17, "Reinstate the AMA Commission to End Health Care Disparities" and provides a series of recommendations that establishes an internal AMA unit charged with advancing health equity for all.

Your Reference Committee noted that in an effort to facilitate a response to Resolution 601-A-17, our AMA Board of Trustees appointed a ten member Health Equity Task Force consisting of those with special interest and expertise in health and health care disparities and representing multiple AMA constituencies. The objectives of the Task Force were to adopt a definition of health equity against which proposed actions could be tested; learn from the contributions of our AMA Commission to End Health Care Disparities; build on AMA's leadership, capabilities, and its advocacy and strategic

efforts; and recommend actions that can be undertaken by our AMA to positively contribute to and communicate a commitment to health equity.

The Task Force met over a period of several months in the winter of 2017-2018 to consider reports, articles, and related AMA policy. It also reviewed the history, actions, and achievements of the Commission to End Health Care Disparities and heard a presentation on current AMA work related to health equity. The Task Force also received written input from staff subject matter experts. In addition to the input from staff, a survey of Federation organizations was conducted to gather information about their work on health equity, health disparities, diversity, and inclusion.

The Task Force concluded unequivocally that the AMA must establish a structural or organizational component charged with looking through the health equity lens to facilitate, coordinate, and enhance current streams of work, and to stimulate additional work that would increase the AMA health equity footprint and impact. This recommendation was offered as the top priority of the Task Force. The Board of Trustees' report outlines features that the proposed organizational component would be expected to have and offers several ideas for future consideration.

Your Reference Committee heard only positive testimony in response to the approach that was taken by our AMA Board of Trustees to identify a replacement entity that will focus on health equity. Additionally, testimony was supportive of the proposed course of action and ongoing commitment by our AMA. An amendment was proposed, and accepted by your Reference Committee, to include advocating for research and data collection on this critical issue. Lastly, your Reference Committee heard testimony calling for a sunset clause due to the anticipated high cost of this initiative. However, your Reference Committee believes an annual report will allow the House of Delegates to remain abreast of our AMA's progress on health equity.

(8) BOARD OF TRUSTEES REPORT 34 - AMA TO PROTECT HUMAN HEALTH FROM THE EFFECTS OF CLIMATE CHANGE BY ENDING ITS INVESTMENTS IN FOSSIL FUEL COMPANIES
RESOLUTION 608 – DIVESTMENT FROM COMPANIES WHOSE PRIMARY BUSINESS IS FOSSIL FUEL

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 34 be amended by addition to read as follows:

Based on the above analysis, the Board of Trustees recommends:

1. that Resolution 607-A-17 not be adopted;

2. that our American Medical Association, AMA Foundation, and any affiliated corporations work in a

timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels;

3. that our AMA choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and

4. that our AMA support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers, and the remainder of this report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 34 be adopted as amended in lieu of Resolution 608 and the remainder of the Report be filed.

Board of Trustees Report 34 comes in response to Resolution 607-A-17, which asked that: (1) our American Medical Association (AMA), AMA Foundation (Foundation), and any affiliated corporations, work in a timely and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) our AMA, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) our AMA support efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policymakers.

In response to Resolution 607-A-17, the Board of Trustees engaged an independent advisor to review the status of fossil fuel divestment for major investment portfolios and to evaluate the potential impact of implementing the resolution.

Based on the thorough analysis and advice of the independent advisor, the Board of Trustees recommends that Resolution 607-A-17 not be adopted, and the remainder of this report be filed.

Resolution 608 calls upon our American Medical Association, Foundation, and any affiliated corporations to work in a timely, and fiscally responsible manner, to the extent

allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.

Resolution 608 further calls upon our AMA, when fiscally responsible, to:

- choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and

- support efforts of physicians and other health professional associations to proceed with divestment, including creating policy analyses, supporting continuing medical education, and informing our patients, the public, legislators, and government policy makers.

Your Reference Committee received extensive and passionate testimony calling upon our AMA to lead efforts to mitigate the health effects of climate change in the public health arena. Those who testified in favor of adopting Resolution 608 also believe that as a group of physicians, our AMA has a moral responsibility to put the health of patients before political or financial considerations. Efforts to turn away from investments in corporations who derive most of their revenue from fossil fuels, thereby contributing to climate change and its health consequences, should be encouraged despite operational challenges. Resolution 608 addresses the fiduciary concerns that were raised in Board of Trustees Report 34 and gives the Board the latitude necessary to fulfill its responsibilities.

(9) RESOLUTION 602 - HEALTH FITNESS PARTNERSHIPS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 602 be <u>amended by addition</u> to read as follows:

RESOLVED, That our American Medical Association promote <u>evidence-based</u> health and wellness <u>programs</u> among AMA members (New HOD Policy); and be it further

RESOLVED, That our AMA further investigate and explore relationships with health and fitness companies to promote <u>evidence-based</u> health and wellness <u>programs</u> among AMA members, including arrangements under which attractive discounts are offered to AMA members. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 602 be adopted as amended.

Resolution 602 calls upon our AMA to establish new policy that promotes health and wellness among AMA Members. Additionally, Resolution 602 calls upon our AMA to investigate and explore relationships with health and fitness companies, including arrangements under which attractive discounts are offered to AMA members.

Testimony favored adoption of new policy promoting the health and wellness of AMA member physicians and medical students. While there is no national health and fitness company that our AMA can partner with to secure AMA member discounts across the country, your Reference Committee favors exploration of this initiative for the purpose of identifying potential opportunities with prominent vendors. Lastly, your Reference Committee received testimony indicating that policy should indicate clearly that our AMA promotes evidenced-based health and wellness programs.

(10) RESOLUTION 603 - ELIMINATING FOOD WASTE THROUGH RECOVERY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 603 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~prioritize~~ consider sustainability and mitigation of food waste in vendor and venue selection (New HOD Policy); and be it further

RESOLVED, That our AMA encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donations. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 603 be adopted as amended.

Resolution 603 calls upon our AMA to establish new policy that prioritizes sustainability and mitigation of food waste in vendor and venue selection. Additionally, Resolution 603 calls upon our AMA to encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donation.

The author of Resolution 603 offered an amendment that will ask our AMA to consider sustainability and mitigation of food waste in its vendor choices and venue selections

instead of making these considerations a priority. This amendment was accepted by your Reference Committee, and no further testimony on Resolution 603 was given.

(11) RESOLUTION 604 - AMA DELEGATION ENTITLEMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 604 be referred with report back at the 2018 Interim Meeting of the House of Delegates.

Resolution 604 calls upon our AMA to continue providing a year-end count of AMA members and an added count of AMA members within the first two weeks of the subsequent year for the purpose of using the higher of the two counts for state and national specialty society delegation entitlements during the current year.

Resolution 604 also calls upon the Council on Constitution and Bylaws to prepare appropriate language to be considered by the AMA House of Delegates that provides for a second count to determine AMA delegation entitlements.

Your Reference Committee heard supportive testimony for this Resolution. The opportunity to positively affect representation in our AMA House of Delegates is used by many delegations as one element in peer-to-peer recruitment. However, it is discouraging for delegations not to see the immediate results of their membership recruitment efforts reflected in their associated delegate count.

Your Reference Committee recognizes the complexity of the membership delegation apportionment process and timing. After lengthy discussion, your Reference Committee could not determine a uniformly acceptable way to implement the method proposed in the resolution. Therefore, your Reference Committee believes that a comprehensive review should be undertaken that focuses on the impact on our entire House of Delegates. A report back at the 2018 Interim Meeting will allow any solution to be implemented for the 2019 membership year.

(12) RESOLUTION 606 - TRAINING PHYSICIANS IN THE ART OF PUBLIC FORUM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 606 be referred.

Resolution 606 calls upon our AMA to establish a program for training physicians in the art and science of conducting public forums in order to ensure that the public is well informed on the health care system of our country.

The author of the Resolution proposed an amendment to focus the Resolution specifically on public speaking, and there was considerable supportive testimony for this

change. Several who testified believed that the resources needed to undertake training in public speaking are already available throughout the Federation and could be utilized instead of creating new training materials. However, others believed that developing the ability of physicians to positively present themselves in the public arena is too important to leave to other organizations, and that training in public speaking could be offered as a valuable AMA member benefit.

Your Reference Committee agrees that public speaking is a much-needed skill that would empower physicians to represent their views more widely and with greater effectiveness. However, your Reference Committee believes that the resources and expertise to most effectively provide this training need to be determined.

(13) RESOLUTION 607 - DISCOUNTED / WAIVED CPT FEES AS AN AMA MEMBER BENEFIT AND FOR MEMBERSHIP PROMOTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 607 be referred.

Your Reference Committee heard mixed testimony on Resolution 607. Those who testified pointed out that offering a discount for CPT's use in medical record systems could be an attractive benefit for AMA members. While CPT products are already discounted 20-30% for AMA members who purchase the products directly, most AMA members do not purchase CPT directly, but use it as part of an integrated electronic medical record system, which is purchased for their group practice and they do not benefit directly from any discounts. In addition, some pointed out that the fees associated with CPT are imposed by vendors on physician practices, not by our AMA. Additionally, our AMA cannot guarantee that vendors would pass along a discount to physician members.

Your Reference Committee appreciates that the Resolution aims to reduce physician fees and possibly enhance member benefits but also recognizes that the idea of discounting or waiving CPT fees associated with electronic medical record systems is a complex topic that could have a significant fiscal impact on our AMA. The Board of Trustees testified that they would welcome referral of Resolution 607.

(14) RESOLUTION 605 - PRACTICING PHYSICIAN DECLINING MEMBERSHIP ANALYSIS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 605 not be adopted.

Resolution 605 calls upon our AMA to publish in its Annual Report any and all aggregate data it has pertaining to reasons physicians are either leaving or not joining our AMA,

including but not limited to, survey data, focus group data, and exit interview data, giving specific attention to those physicians in the "Young," "Mature," and "Senior" membership categories.

Testimony on Resolution 605 was mixed. Delegates who supported the Resolution believed data our AMA possesses that delineates reasons AMA members discontinue their membership would be very helpful to use in their own organizations' recruitment and retention efforts. Those who opposed the Resolution agreed that while such data would be helpful, a publicly available annual report is not the best way to share this information.

Your Reference Committee agrees with the author as to the usefulness of AMA data in assisting recruitment and retention efforts. Your Reference Committee also believes that a public document such as an annual report should not be used to publish this data. The Board of Trustees has expressed its willingness to share this data with interested Federation members upon request.

(15) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 1 be filed.

Board of Trustees Report 1 introduces our AMA's 2016 and 2017 Consolidated Financial Statements and an Independent Auditor's report, which are included in a separate document titled, "2017 Annual Report" that was made available with the Handbook materials.

On behalf of our entire AMA membership, your Reference Committee extends appreciation to the Board of Trustees for executing sound fiscal responsibility throughout this past year, which was the 17th time in the last 18 years that our AMA has reported positive operating results.

Madam Speaker, this concludes the report of Reference Committee F. I would like to thank Anthony Armstrong, MD, A. Patrice Burgess, MD, Melissa J. Garretson, MD, Jerry L. Halverson, MD, Ann R. Stroink, MD, Greg Tarasidis, MD, and all those who testified before the Committee.

Anthony Armstrong, MD
Ohio

Jerry L. Halverson, MD
American Psychiatric Association

A. Patrice Burgess, MD
Idaho

Ann R. Stroink, MD
Congress of Neurological Surgeons

Melissa J. Garretson, MD
American Academy of Pediatrics

Greg Tarasidis, MD
South Carolina

Julia V. Johnson, MD
American Society for Reproductive Medicine
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee G

Theodore A. Calianos, II, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 717 – Impact of the High Capital Cost of Hospital EHRs on the Medical Staff

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

2. Board of Trustees Report 37 – Eliminate the Requirement of H&P Update
3. Board of Trustees Report 39 – Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models
4. Council on Medical Service Report 4 – Health Plans' Medical Advice
5. Council on Medical Service Report 5 – Financing of Long-Term Services and Supports
6. Council on Medical Service Report 6 – Integrating Precision Medicine into Alternative Payment Models
7. Resolution 706 – Ensuring Medicare Coverage for Long Term Care
8. Resolution 710 – Code Status Through the Continuum of Care
9. Resolution 713 – Private Equity Firms
10. Resolution 714 – Laboratory Benefit Managers
11. Resolution 715 – The Obligatory Nature and Enduring Purpose of the Self-Governed Organized Medical Staff

RECOMMENDED FOR REFERRAL

12. Board of Trustees Report 31 – Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization
13. Resolution 701 – Employed Physicians Bill of Rights
14. Resolution 702 – Basic Practice Professional Standards of Physician Employment
15. Resolution 704 – Non-Payment and Audit Takebacks by CMS
16. Resolution 707 – Health Plan Payment of Patient Cost-Sharing
17. Resolution 712 – Alternative Payment Models and Vulnerable Populations

RECOMMENDED FOR REFERRAL FOR DECISION

18. Resolution 705 – Modify the Clinical Laboratory Improvement Amendment of 1988
19. Resolution 716 – Hospital Closures and Physician Credentialing

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

20. Resolution 703 – Economic Credentialing
21. Resolution 711 – Compensation for Pre-Authorization Requests

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 708 – Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission
- Resolution 709 – Prior Authorization for Durable Medical Equipment

(1) RESOLUTION 717 - IMPACT OF THE HIGH CAPITAL COST OF HOSPITAL EHRS ON THE MEDICAL STAFF

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 717 be adopted.

Resolution 717 asks that our AMA study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to their impact on downsizing of medical staffs and its effect on physician recruitment and retention.

Testimony on Resolution 717 was minimal and supportive. An amendment was offered to expand the requested study to include not only the effect on physician recruitment and retention but also the effect on patient safety and patient care. However, your Reference Committee believes this amendment expands the scope of the requested study well beyond its original intent and constitutes a separate study. Accordingly, your Reference Committee recommends that Resolution 717 be adopted.

(2) BOARD OF TRUSTEES REPORT 37 – ELIMINATE THE REQUIREMENT OF H&P UPDATE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 37 be amended by addition of a new Recommendation to read as follows:

That our AMA work with the Centers for Medicare and Medicaid Services to redefine the requirement that an update to a history and physical within twenty-four hours of a surgery/procedure to mean that the provider has reviewed pertinent data and the original documented history and physical is sufficient information to determine that it is safe to proceed with the planned surgery or procedure. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 37 be adopted as amended and the remainder of the report be filed.

Board of Trustees Report 37 recommends that Resolution 710-A-16 not be adopted and the remainder of the report be filed.

A member of the Board of Trustees introduced the report noting that the Board has deliberated on this issue numerous times. Testimony on the report was mixed. Some speakers noted that the issue of the H&P update is a patient safety issue while others

noted that the requirement is onerous and misinterpreted. Additional testimony highlighted that interpretation of preoperative clinical evaluation requirements vary. Your Reference Committee recognizes the complex nature of this issue and offers an amendment to address concerns raised in testimony. Accordingly, your Reference Committee recommends that Board of Trustees Report 37 be adopted as amended and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 39 – EXPANDING ACCESS TO SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH/SOCIAL DETERMINANTS OF HEALTH IN PAYMENT MODELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 39 be amended by addition and deletion to read as follows:

National Health Information Technology D-478.995

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 continued ~~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, with physician input, 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.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health ~~SDH~~ templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 39 be adopted as amended and the remainder of the report be filed.

Board of Trustees Report 39 recommends amending Policy D-478.995 by addition to state that our AMA urge EHR vendors to adopt SDH templates without adding further cost for physicians.

A member of the Board of Trustees introduced the report. Testimony was largely supportive of the report. In particular, testimony asked to modify Policy D-478.995 part 2(D) to delete the word “more” and replace it with “continued” to accurately reflect the past and current research that has occurred and the need to continue to update that research. Moreover, testimony noted physician input should be garnered in the CMS development of any minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs, and recommends an amendment to that end. Additionally, testimony requested that not only should EHR vendors adopt social determinants of health (SDH) templates, but also, they should be created with input from our AMA and other stakeholders and should do so without adding documentation burden for physicians. Your Reference Committee agrees and accepts these amendments.

Moreover, testimony stated that one of the original referred resolutions requested fair compensation for use of SDH screening tools and interventions in the clinical setting. Your Reference Committee understands this concern; however, your Reference Committee notes that, in a Proposed Rule due by early July, CMS is expected to discuss potential modifications and/or a process to consider modifications to E/M guidelines, which may address the concern. Accordingly, your Reference Committee recommends that Board of Trustees Report 39 be adopted as amended and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 4 - HEALTH PLANS' MEDICAL ADVICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 5 of Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

5. That our AMA policy affirm that medical advice services provided by health plans should adhere to the following guidelines:
a) The primary goals of health plans’ medical advice services should be to inform, educate and empower patients to make good health care choices and receive timely and appropriate care. These services should not be used to assess patients in order to inform diagnosis or treatment.
b) Health plans’ medical advice services should comply with state licensure laws, state medical, nursing, or other relevant practice acts, state scope of practice laws, and other relevant requirements within the state in which enrollees receive services.

c) Staff providing health plans' medical advice services should have a level of knowledge and training no less than a registered nurse ~~(eg, nurse with a bachelor of science in nursing, advanced practice registered nurse, or physician assistant)~~ and be appropriately licensed in the state in which enrollees receive services.

d) Qualified physicians should be available for consultation to persons offering medical advice services at all times that the medical advice service is advertised as available.

e) Health plans should have policies and procedures in place that allow medical advice services to quickly and effectively respond to enrollees' health concerns.

f) Health plans should have policies and procedures in place to ensure that medical advice service providers routinely provide feedback to enrollees' treating physicians regarding the nature of the enrollees' contacts.

g) Health plans should ensure that non-clinical staff who may be screening enrollee calls or emails for the medical advice service are neither providing medical advice nor making medical decisions.

h) Health plans' medical advice services staff should fully disclose relevant training and credentials, and not misrepresent themselves to users. (New HOD Policy)

RECOMMENDATION B:

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

Council on Medical Service Report 4 recommends a series of guidelines that health plans' medical advice services should adhere to. The report also recommends new policy stating that real-time interactions between health plans and enrollees that are utilized for patient assessments and result in the creation of treatment plans constitute the practice of medicine.

Testimony on Council on Medical Service Report 4 was supportive. A member of the Council on Medical Service introduced the report, noting that while it is not unusual for health plans to offer medical advice services, there have been concerns over the years regarding how these services are managed and whether staff are appropriately qualified. An amendment was offered to include nurses with associate degrees in nursing to the parentheses of Recommendation 5(c). An additional amendment was offered to Recommendation 5(d) to clarify that qualified physicians should be available for consultation to persons offering medical advice services at all times that the service is advertised as available. Your Reference Committee recommends deletion of the parenthetical language in Recommendation 5(c) for simplification purposes and also the addition of the clarifying language in 5(d). Accordingly, your Reference Committee

recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(5) COUNCIL ON MEDICAL SERVICE REPORT 5 - FINANCING OF LONG-TERM SERVICES AND SUPPORTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 5 be amended by addition to read as follows:

4. That our AMA support adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees. (New HOD Policy)

RECOMMENDATION B:

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

Council on Medical Service Report 5 recommends a set of recommendations to modify the current financing structure of long-term services and supports with options that weave together financing reforms through publicly funded programs and private insurance.

A member of the Council on Medical Service introduced the report. The member highlighted the increased national spending for long-term services and supports (LTSS) and that the demand for LTSS is expected to double in the next thirty years as the baby boomer generation ages. Testimony stated that there are few affordable options in the private insurance market for LTSS coverage and limited coverage under Medicare. Consequently, Medicaid accounts for over half of national spending on LTSS and is the primary payer across the nation for LTSS. The Council member provided an overview of the report recommendations saying that the Council is proposing a multi-pronged approach to alter the financing and viability through a mix of public and private reforms. Finally, the Council noted that, while there may be no single, comprehensive solution to address the growing demand for LTSS, the Council believes that its recommendations represent a pragmatic step forward to address the needs of an aging population by shifting away from last-resort public financing to a more sustainable system of meaningful insurance.

Testimony on Council on Medical Service Report 5 was unanimously supportive. Testimony proposed that long-term care insurance (LTCI) coverage as part of workplace automatic enrollment should have an opt-in provision rather than an opt-out provision. However, a member of the Council noted that supporting an opt-out provision was carefully considered by the Council and mirrors the structure of many employer-sponsored retirement savings accounts. Additional testimony noted that employer-based

long-term care insurance should be portable and transferable as employees transition to various jobs throughout their careers. Your Reference Committee agrees and proposes an amendment to that end. Accordingly, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

(6) COUNCIL ON MEDICAL SERVICE REPORT 6 - INTEGRATING PRECISION MEDICINE INTO ALTERNATIVE PAYMENT MODELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 8 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

8. That our AMA encourage APMs to ~~consider measuring~~ measure patient outcomes and quality improvements over time to allow for the use of precision medicine tests and therapeutics that have clinical value. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 6 be amended by addition of a new Recommendation to read as follows:

That our AMA reaffirm Policy D-185.980, which encourages public and private payers to adopt a series of processes and methodologies for determining coverage and payment for genetic/genomic precision medicine. (Reaffirm HOD Policy)

RECOMMENDATION C:

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

Council on Medical Service Report 6 recommendations encourage APMs to consider the value of precision medicine and to integrate precision medicine approaches as appropriate and as recommended by national medical specialty societies.

Testimony was supportive of Council on Medical Service Report 6. A member of the Council on Medical Service introduced the report, noting that precision medicine innovations are occurring simultaneously with significant payment and delivery reforms, and that there is value to considering precision medicine approaches within alternative

payment models. One speaker asked that Recommendation 8 be strengthened. Another requested reaffirmation of Policy D-185.980, which addresses payment and coverage for genetic/genomic precision medicine. Your Reference Committee agrees, and recommends that Council on Medical Service 6 be adopted as amended and the remainder of the report be filed.

(7) RESOLUTION 706 - ENSURING MEDICARE COVERAGE FOR LONG TERM CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 706 be amended by deletion to read as follows:

~~RESOLVED, That our American Medical Association support the concept of increasing the existing 20-day limit of full Medicare coverage for a patient's skilled nursing facility stay (New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work to identify additional mechanisms by which ~~the additional~~ patients' out-of-pocket costs for ~~this~~ skilled nursing facility care can be fairly covered. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 706 be adopted as amended.

Resolution 706 asks that our AMA support the concept of increasing the existing 20-day limit of full Medicare coverage for a patient's skilled nursing facility stay; and work to identify mechanisms by which the additional costs for this care can be fairly covered.

Testimony on Resolution 706 was supportive. A member of the Council on Medical Service offered an amendment to strike the first resolve and to amend the second resolve. In offering the amendment, the Council member stated that though the Council agrees with the goal of Resolution 706, it is important to have more information on this issue before calling for this specific action, including how many people exceed the 20 days and what percentage of those individuals are not covered by a Medicare Advantage plan or supplemental plan where co-pays and premiums may be covered for the beneficiary. Therefore, in the absence of that data, the Council thought it best to broadly support the idea of lowering out-of-pocket costs for patients in skilled nursing

facilities without being overly prescriptive. Moreover, the Council questioned why we should call for no co-payments on skilled nursing facility stays but not for other services such as hospital days and physician services. Finally, the Council testified that Medicare coverage of skilled nursing facility services is intended to be used for rehabilitation, not for long-term care. As such, the Council highlighted Council on Medical Service Report 5 on financing of long-term services and supports offering pragmatic and comprehensive steps to addressing the complex issue of long-term care coverage. Your Reference Committee finds this testimony persuasive and accepts the amendment. Accordingly, your Reference Committee recommends that Resolution 706 be adopted as amended.

(8) RESOLUTION 710 - CODE STATUS THROUGH THE CONTINUUM OF CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 710 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to streamline ~~revise or rescind the rules that prevent~~ transfer of code status across the continuum of care ~~in order to better meet the needs of our patients and our health care system in a comprehensive, cohesive, and more cost-effective manner~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 710 be adopted as amended.

Resolution 710 asks that our AMA work with the Centers for Medicare and Medicaid Services to revise or rescind the rules that prevent transfer of code status across the continuum of care in order to better meet the needs of our patients and our health care system in a comprehensive, cohesive, and more cost-effective manner.

There was minimal supportive testimony on Resolution 710 stating that this resolution is a thoughtful step forward to address the issue of code status. An amendment was offered to simplify the resolution, and your Reference Committee accepts this amendment. Accordingly, your Reference Committee recommends that Resolution 710 be adopted as amended.

(9) RESOLUTION 713 - PRIVATE EQUITY FIRMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 713 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study, with report back at the ~~2018 Interim~~ 2019 Annual Meeting, the effects on the healthcare marketplace of venture capital/private equity (PE) firms acquiring a majority and/or controlling interest in entities that manage physician practices, ~~stake in physician private independent, small group and large group practices, including, but not limited to,~~ such ~~topics~~ as:

- the degree of venture capital/PE penetration and investment in the healthcare marketplace;
- the impact on physician practice and independence;
- patient access;
- resultant trends in the use of unsupervised, independently practicing non-physician extenders;
- long term financial viability of ~~purchased~~ practices;
- effects of ownership turnovers and bankruptcies on patients and practice patterns;
- effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces;
- and the relative impact venture capital/PE transactions ~~purchases~~ have on the paths and durations of junior, mid-career and senior physicians (Directive to Take Action);

and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 713 be adopted as amended.

Resolution 713 asks that our AMA study, with report back at the 2018 Interim Meeting, the effects on the healthcare marketplace of venture capital/PE firms acquiring majority and/or controlling stake in physician private independent, small group and large group practices; and that, in order to address the particular concerns of physicians entering into management service organization contracts, our AMA amend the AMA Annotated Model Physician-Group Practice Employment Agreement (H-215.981).

Testimony was supportive of Resolution 713. Your Reference Committee discussed broadening the requested study to include corporate ownership of physician practices beyond venture capital/private equity firms, which was proposed by some speakers.

However, your Reference Committee heard substantial testimony regarding the need to specifically study venture capital/private equity firm acquisitions of physician practices and the impact of these acquisitions on practices and patients. Your Reference Committee believes that a separate report on corporate control of physician practices may benefit physicians, but your Reference Committee does not wish to broaden the purview of the study requested by Resolution 713. Your Reference Committee concurs with amendments offered to the first Resolve, including an amendment asking for a report back at the 2019 Annual Meeting instead of the 2018 Interim Meeting. Your Reference Committee believes that additional time is needed to address the numerous topics outlined in resolution. Additional amendments to the first Resolve are suggested based on your Reference Committee's consultation with our AMA's Office of General Counsel. Accordingly, your Reference Committee recommends that Resolution 713 be adopted as amended.

(10) RESOLUTION 714 - LABORATORY BENEFIT MANAGERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following be adopted in lieu of Resolution 714:

RESOLVED, That our American Medical Association support efforts to reduce laboratory benefit management policies that result in delays in patient care, reduced patient access, or increased patient costs without clinical justification; (New HOD Policy) and be it further

RESOLVED, That our AMA support that any policies regarding laboratory benefit management arrangements preclude any potential conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory. (New HOD Policy)

Resolution 714 asks that our AMA adopt policy that supports the adoption of laws, regulations and public or private sector policies regarding laboratory benefit management arrangements to preclude: (1) Any potential financial conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory; (2) Health insurance payer constraints on ordering physician discretion for referrals made to any in-network laboratory or pathology providers when such referrals are medically and ethically appropriate; (3) Any adverse claims impact on the laboratory or pathology provider who receives a lawful order from a health care provider for medically necessary services, based upon a compliance failure in the laboratory benefit management ordering process; and (4) The implementation by a health insurance payer of prior authorization or prior notification imposed on ordering physicians for any pathology or laboratory test ordered on a patient specimen obtained in a hospital or ambulatory surgical center.

Overall, testimony on Resolution 714 was supportive. An amendment was offered to remove the phrase “in network” because all laboratory tests are affected by these potential conflicts of interest, whether in-network or not. Testimony by other parties supported the removal of this language. A member of the Council on Medical Service testified that Resolution 714 may be overly prescriptive at this juncture and instead proposed an alternate resolution recognizing that our AMA currently does not have policy specific to laboratory benefit managers and believes that our AMA should adopt broad foundational policy to begin supporting advocacy in this area. Your Reference Committee agrees and believes that this language not only touches on most of the concerns in Resolution 714 but also addresses concerns raised in testimony over the phrase “in network,” the issue of laboratory prior authorization, as well as testing location. However, your Reference Committee believes that the inclusion of a resolve addressing any potential conflict of interest is warranted. As such, your Reference Committee recommends that an alternate resolution be adopted in lieu of Resolution 714.

(11) RESOLUTION 715 - THE OBLIGATORY NATURE AND ENDURING PURPOSE OF THE SELF-GOVERNED ORGANIZED MEDICAL STAFF

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 715 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-225.942 Physician and Medical Staff Bill of Rights by addition to read as follows:

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. ~~These personal interactions between medical staff physicians and their patients give rise to a heightened and incomparable accountability to patients that is not shared by hospital administrators or members of the governing body.~~ This ~~unparalleled~~ accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization’s governing body.
b. The responsibility to provide leadership and work collaboratively with the health care organization’s administration and governing body to continuously improve patient care and outcomes.
c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:
a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organization’s administration or governing body.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:
a. The responsibility to work collaboratively with other members and with the health care organization's administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:
a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 715 be adopted as amended.

Resolution 715 asks that Policy H-225.942 be amended by addition of a Preamble.

Testimony was supportive of Resolution 715, which adds a preamble developed by the Organized Medical Staff Section to Policy H-225.942. Your Reference Committee agrees with concerns regarding a statement in the preamble's second paragraph that could alienate hospital administrator colleagues and physician leaders who are involved in governance, and recommends deletion of that language. Your Reference Committee recommends that Resolution 715 be adopted as amended.

(12) BOARD OF TRUSTEES REPORT 31 – PHYSICIAN BURNOUT AND WELLNESS CHALLENGES, PHYSICIAN AND PHYSICIAN ASSISTANT SAFETY NET, IDENTIFICATION AND REDUCTION OF PHYSICIAN DEMORALIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 31 be referred.

Board of Trustees Report 31 recommends amending Policy D-310.968 by addition to encourage hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization; continue to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being; address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and develop and promote mechanisms by which organizations and physicians can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being at the system level.

Testimony on Board of Trustees Report 31 was mixed, with several speakers strongly supporting the report and others asking for a range of amendments and more

information about solutions to physician wellness challenges and demoralization. A member of the Board of Trustees introduced the report, noting that it addresses three resolutions introduced at the 2017 Interim Meeting that were referred for report back at this meeting. Several speakers testified in support of an amendment to create an AMA caucus or task force on physician health and wellness. Some speakers were concerned with the ramifications of physicians self-reporting burnout, and also the appropriateness of encouraging hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization. Speakers also expressed various opinions regarding definitions and use of the terms burnout and demoralization. Because of the depth and breadth of the numerous amendments offered in testimony, your Reference Committee believes that additional study is needed. Accordingly, your Reference Committee recommends that Board of Trustees 31 be referred.

(13) RESOLUTION 701 - EMPLOYED PHYSICIANS BILL OF RIGHTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 701 be referred.

Resolution 701 asks that our AMA adopt an “Employed Physicians Bill of Rights.”

Testimony strongly supported referral of Resolution 701. Several speakers acknowledged the complexities associated with the eleven Resolve clauses and the need for each to be examined individually and reviewed for consistency with AMA policy. Your Reference Committee agrees, and recommends that Resolution 701 be referred.

(14) RESOLUTION 702 - BASIC PRACTICE PROFESSIONAL STANDARDS OF PHYSICIAN EMPLOYMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 702 be referred.

Resolution 702 asks that our AMA support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options: (1) Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered; (2) Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered; (3) Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems; (4) Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other

"greater societal good" organizations; and (5) Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.

Testimony was generally supportive of the intent of Resolution 702. While acknowledging the importance of the topics addressed by the resolution, speakers also testified that the suggested best practices need further study and refinement. It was further noted that some of the best practices are addressed by existing AMA policy. There was strong negative testimony regarding option 5 on establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county region. Several speakers asked that the item be referred. Accordingly, your Reference Committee recommends Resolution 702 be referred.

(15) RESOLUTION 704 - NON-PAYMENT AND AUDIT TAKEBACKS BY CMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 704 be referred.

Resolution 704 asks that our AMA seek through legislation and/or regulation policies opposing claim nonpayment due to minor wording or clinically insignificant documentation inconsistencies; seek through legislation and/or regulation policies opposing extrapolation of overpayments based on minor inconsistencies; and seek through legislation and/or regulation policies opposing bundled payment denial based on minor wording or clinically insignificant documentation inconsistencies.

Your Reference Committee heard limited supportive testimony on Resolution 704. The sponsor of Resolution 704 testified that this resolution would complement existing fraud and abuse policy, as it specifically addresses the penalization of physicians for minor wording and clinical inconsistencies in documentation. A member of the Council on Medical Service suggested reaffirmation of several existing policies. The Council testified that this issue is addressed by policy stating that the AMA will respond vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse (H-175.985). It is equally addressed by policy stating that the AMA will seek congressional intervention to halt practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors (H-175.979). In addition, the member of the Council stated that policy directs the AMA to urge CMS to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges (D-330.905).

Additional testimony in support of Resolution 704 was offered stating that this addresses a very important issue not currently addressed by AMA policy. More specifically, testimony noted that practices have had entire patient stays denied due to minor clerical errors, resulting in non-payment, and that these errors have no consequence on patient care or safety, but are rather due to routine human error. Testimony further stated that this resolution should also be considered in light of physician burnout and the pressure to produce perfect documentation causes major pressures on physicians and is ultimately detrimental patients.

A majority of the testimony was in support of referral stating that, while current AMA policy does address the larger issue reflected in the resolution, reaffirmation would not be appropriate in this case. Instead, referring this resolution would allow our AMA to study the breadth of the issue and determine what constitutes a minor or clinically insignificant error.

Your Reference Committee acknowledges that the issue of minor documentation inconsistencies leading to unjustified payment denials is of great frustration to physicians. Further, your Reference Committee believes that existing policy does not point to the specific issue of minor errors in documentation; rather it is more concerned with minor errors in billing and enrollment. Moreover, your Reference Committee believes that phrases such as “minor wording” and “clinically insignificant” should be defined before moving forward on this issue. Accordingly, your Reference Committee recommends referral.

(16) RESOLUTION 707 - HEALTH PLAN PAYMENT OF PATIENT COST-SHARING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 707 be referred.

Resolution 707 asks that our AMA urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance and deductibles.

Testimony provided by the sponsor was the only testimony on Resolution 707. The speaker called for referral of Resolution 707 due to the complexity of this issue and varying considerations. Your Reference Committee agrees that this issue warrants study. However, your Reference Committee believes that, due to the potential unintended consequences and competing interests within this issue, immediate report back at Interim 2018 will not allow for the requisite research and consideration that this resolution demands. Therefore, your Reference Committee does not recommend immediate report back at Interim 2018 as requested by the sponsor. Accordingly, your Reference Committee recommends that Resolution 707 be referred.

(17) RESOLUTION 712 - ALTERNATIVE PAYMENT MODELS AND VULNERABLE POPULATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 712 be referred.

Resolution 712 asks that our AMA study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable

populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

Testimony on Resolution 712 was supportive. Regarding the second resolve clause, your Reference Committee notes that our AMA does not have policy stating that quality should be based on peer groups. Rather, in comment letters, our AMA has generally stated that there needs to be a risk adjuster for socioeconomic and demographic issues. Moreover, your Reference Committee highlights that the issue of peer group evaluation is a regulatory issue, not a legislative issue. Therefore, your Reference Committee believes it is premature to adopt the second resolve of Resolution 712 without first conducting the study called for in the first resolve. Accordingly, your Reference Committee recommends that Resolution 712 be referred.

(18) RESOLUTION 705 - MODIFY THE CLINICAL LABORATORY IMPROVEMENT AMENDMENT OF 1988

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 705 be referred for decision.

Resolution 705 asks that our AMA adopt the position that it is proper to remove the CLIA certification mandate requirement for physicians who only use CLIA-waived tests and physician-performed microscopy.

Testimony on Resolution 705 was mixed, with substantial testimony both supportive and opposed to the item. Some speakers emphasized the need for relief from Clinical Laboratory Improvement Amendments of 1988 regulations. However, additional testimony spoke to the importance of these regulations to ensure the accuracy and reliability of all lab testing results regardless of where these tests are performed. Your Reference Committee recommends that Resolution 705 be referred for decision.

(19) RESOLUTION 716 - HOSPITAL CLOSURES AND PHYSICIAN CREDENTIALING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 716 be referred for decision.

Resolution 716 asks that our AMA work with appropriate stakeholders, such as the AMA Organized Medical Staff Section and National Association Medical Staff Services (NAMSS), to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital, or one of its departments, at the time of closure, and report back at the 2018 Interim Meeting.

Testimony on Resolution 716 was supportive. Your Reference Committee notes that not only would the cost of implementing Resolution 716 be significant, but also, there are many unanswered questions about the demand for such a service and how it would

work. Additionally, your Reference Committee is unsure if our AMA is the best organization to take up this issue and believes that that determination is best left up to the Board of Trustees. Further, testimony noted that producing a credentialing repository as called for in Resolution 716 may be considered an AMA member benefit, and again your Reference Committee believes that consideration of a potential new member benefit is best left to the Board of Trustees. Therefore, your Reference Committee recommends that Resolution 716 be referred for decision.

(20) RESOLUTION 703 - ECONOMIC CREDENTIALING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-180.963 be reaffirmed in lieu of Resolution 703.

Resolution 703 asks that our AMA vigorously oppose clinical credentialing based solely on surgical and non-surgical case volume when there is no other basis for questioning the physician's ability to function with skill and safety.

Testimony was supportive of the intent of Resolution 703. Members of the Council on Medical Service and the Organized Medical Staff Section pointed out that existing AMA policy states that volume indicators should not be used as the sole criteria for credentialing. Your Reference Committee believes that the concerns expressed by some speakers regarding the lack of evidence linking volume to quality are sufficiently addressed by Policy H-180.963. Accordingly, your Reference Committee recommends that Policy H-180.963 be reaffirmed in lieu of Resolution 703.

Volume Discrimination Against Physicians H-180.963
The AMA recommends that volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance; and affirms that volume indicators should not be used as the sole criteria for credentialing and reimbursement and that, when volume indicators are used, allowances should be made for physicians starting practice. (Sub. Res. 101, A-96 Reaffirmed: CMS Rep. 8, A-06 Reaffirmed: BOT Rep. 3, A-09)

(21) RESOLUTION 711 - COMPENSATION FOR PRE-AUTHORIZATION REQUESTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-320.939 be reaffirmed in lieu of Resolution 711.

Resolution 711 asks that our AMA petition the Centers for Medicare and Medicaid Services that CPT code 99080 be reimbursed by Medicare.

Your Reference Committee heard limited testimony on this issue. A member of the Council on Medical Service testified that at last year's Annual Meeting, the Council presented a report on prior authorization that considered potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures. Ultimately, the Council recommended that the AMA continue its extensive advocacy campaign based on the Prior Authorization and Utilization Management Reform Principles released in 2017 and complete ongoing research on prior authorization burdens. A member of the Council went on to outline the numerous challenges with making payment for prior authorization a priority such as insufficient payment, logistical challenges (e.g. unlikely that plans would pay for prior authorization on a service that was denied), and contractual provisions that require physicians to complete prior authorization protocols and bar practices from billing patients for prior authorization. A member of the Council further stressed that adopting policy requesting payment for prior authorization would legitimize prior authorization and directly conflict with our AMA's efforts to reduce the overall volume of drugs and medical services requiring authorization, as well as detract from the patient impact message that highlights the care delays and negative clinical outcomes associated with prior authorization. While recognizing the associated administrative hassles and clinical burdens, a member of the Council testified it is most prudent that our AMA refrain from actively seeking physician compensation for prior authorizations due to the logistical and practical challenges just noted, as well as the risk of undermining the collaborative outreach efforts associated with the Prior Authorization and Utilization Management Reform Principles. The member of the Council on Medical Service went on to urge reaffirmation of existing AMA policy that calls for our AMA to continue its ongoing, extensive advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other research, and the AMA Prior Authorization Toolkit, which is aimed at reducing administrative burdens and improving patient access to care; and oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

Testimony stated that Resolution 711 would add a different dimension to existing policy, as it would require payment for the uncompensated work that providers do. Additional testimony cautioned that prior authorization is rationing by irritation. Further, testimony highlighted that requiring payment for prior authorization could lead insurers to decrease the volume of prior authorizations. An amendment was offered to request that the AMA petition the Centers for Medicare and Medicaid "every year" citing that prior authorization is an unfunded mandate.

A member of the Board of Trustees acknowledged the extensive advocacy work that our AMA has undertaken. This year, our AMA's prior authorization advocacy has been highly visible and effective. Key elements of our AMA's current work on this issue include research, direct insurer engagement, state legislation, grassroots efforts and practice education. The testimony also cited that our AMA released a 2017 physician survey which has provided valuable data detailing the significant impact of prior authorization on both patients and physicians and has achieved substantial media attention. Further, our AMA will be fielding a patient survey this summer to further assess how prior authorization affects patients and their care. Additionally, our AMA and a coalition of

sixteen other provider and patient organizations released a set of 21 Prior Authorization and Utilization Management Reform Principles in January 2017. These principles were used to initiate a broad outreach campaign to health plans, benefit managers, and accreditation organizations to urge reform in prior authorization programs. One initial and noteworthy outcome of this outreach was the January 2018 release by the AMA, American Hospital Association, American's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association of the Consensus Statement on Improving the Prior Authorization Process. Notably, the consensus statement reflects an agreement to pursue reduced overall volume in prior authorizations through both selective application of these requirements and regular review and adjustment of the drugs and services on authorization lists. Moreover, a member of the Board of Trustees highlighted that our AMA continues to work with state and specialty societies to enact legislation to protect physicians and patients from prior authorization burdens.

Furthermore, your Reference Committee notes that our AMA has built grassroots activities into its prior authorization reform campaign. Prior authorization–related content has been added to both the Patients Action Network and Physicians Grassroots Network websites. Both sites include a "share your story" call to action, which is echoed in an accompanying social media campaign. Additional enhancements of our AMA's grassroots web presence are underway, and an updated site will be launched this summer. Moreover, our AMA also offers educational resources to help physicians and their staff reduce the manual burdens associated with prior authorization and transition to automated processes. A new, three-part educational video series demonstrates the workflow improvements and other advantages of implementing pharmacy electronic prior authorization transactions that integrate with electronic health record systems and offers tips on how practices can start using this technology. This activity has been approved for *AMA PRA Category 1 Credit™.*

Your Reference Committee recognizes that few phrases draw the ire of physicians and their staff more than prior authorization and commends the sponsors for trying to address this major pain point. As a result of this time-intensive and administratively burdensome process, many physicians justifiably would like to receive payment for completing prior authorization processes. While your Reference Committee understands this position and agrees that physicians should be properly compensated for their time, several considerations potentially limit the effectiveness and practicality of such an advocacy initiative, and your Reference Committee finds that adopting Resolution 711 will not remedy the problem. As reflected during testimony, requesting payment for prior authorization would legitimize the practice, potentially leading to more treatments and services requiring prior authorization. Your Reference Committee is concerned that instead of deterring prior authorization practices if they are paid for, these costs may pass through the insurance and add on costs to premiums and employers. Moreover, your Reference Committee is concerned that, should our AMA undertake and achieve widespread compensation for prior authorization, a perverse and unintended consequence could be an overall increase in prior authorization requirements, as health plans could use payment as justification for additional utilization review. As such, your Reference Committee believes that our AMA should continue with the extensive advocacy efforts already in process on this important issue and not redirect valuable resources—or weaken the campaign that is built on reducing the overall volume of prior authorizations—by focusing on compensation for this

administrative work. Accordingly, your Reference Committee recommends that Policy H-320.939 be reaffirmed in lieu of Resolution 711.

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (CMS Rep. 08, A-17; Reaffirmation: I-17)

Madam Speaker, this concludes the report of Reference Committee G. I would like to thank Steven Falcone, MD, Brian Gavitt, MD, Peter Rahko, MD, Joseph Adashek, MD, Kathryn Lombardo, MD, Michele Manahan, MD, and all those who testified before the Committee.

Steven Falcone, MD, MBA
American College of Radiology

Joseph Adashek, MD, FACOG
(Alternate)
Nevada

Brian Gavitt, MD, MPH, FACS
American College of Surgeons

Kathryn Lombardo, MD (Alternate)
Minnesota

Peter Rahko, MD
American Society of Echocardiography

Michele Manahan, MD (Alternate)
American Association of Plastic Surgeons

Theodore A. Calianos, II, MD, FACS
Massachusetts
Chair