

REPORTS OF REFERENCE COMMITTEES

2017 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

(1) BOARD OF TRUSTEES REPORT 12 - 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 12 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 12 adopted and the remainder of the report filed.

Board of Trustees Report 12 recommends that the American Association of Neuromuscular & Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery, Inc., American Society of Clinical Oncology, American Society of Maxillofacial Surgeons, American Society of Plastic Surgeons, Radiological Society of North America and the Society of Thoracic Surgeons are in compliance with the five-year review requirements of specialty organizations represented in the HOD and retain representation in the AMA House of Delegates. It also recommends that since the Society of Nuclear Medicine & Molecular Imaging failed to meet the requirements for continued representation in the AMA HOD, they be placed on probation and be given one year to increase their AMA membership. Finally, the report recommends that since the American Academy of Sleep Medicine and the American Society of Cytopathology failed to meet the requirements for continued representation after a year's grace period to increase membership, that they not retain representation in the House of Delegates.

Testimony centered on the third recommendation of the report. The American Academy of Sleep Medicine gave updated member numbers, however that number still falls under the 20% threshold. A member of the Council on Constitution and Bylaws clarified that the only options for action in this instance are to either fully renew membership or not renew. It was noted that removal from the House of Delegates does not impact an organizations membership in the SSS, and those affected organizations are encouraged to participate in that capacity as they are still considered to be valued resources. In keeping with the established bylaws, your Reference Committee recommends that Board of Trustees Report 12 be adopted.

(2) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 - AMENDED
BYLAWS - SPECIALTY SOCIETY REPRESENTATION - FIVE-YEAR
REVIEW

RECOMMENDATION:

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

HOD ACTION: The recommendations in Council on Constitution and Bylaws Report 1 adopted and the remainder of the report filed.

This report and the recommendations contained therein clarify the actions which must be taken by the HOD regarding specialty societies found to be noncompliant after a one year grace period.

Your Reference Committee did not receive any testimony for this item. As such, your Reference Committee recommends that Council on Constitution and Bylaws Report 1 be adopted.

(3) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 - ETHICAL PHYSICIAN CONDUCT IN THE MEDIA

RECOMMENDATION:

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

HOD ACTION: The recommendations in Council on Ethical and Judicial Affairs Report 2 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 2 provides guidance for physicians who are speaking to or appearing in the media. This report was submitted and referred back to the Council at A-17 due to concerns surrounding language regarding speaking to only one's specialty. This language has been addressed in the current iteration of the report, allowing for physicians to speak on issues for which they have the requisite experience.

Testimony supported adoption of this report and appreciated the change in language from the last iteration of the report. Your Reference Committee agreed with testimony suggesting that "politics" and "public health" are relevant and influential areas (along with the noted areas of "medicine, journalism and entertainment"). However, your Reference Committee felt that the guidance offered in the report (particularly (c) and (d)) adequately covers these areas. Your Reference Committee believes this to be a timely and important report and therefore recommends that Council on Ethical and Judicial Affairs Report 2 be adopted.

(4) RESOLUTION 2 - INTIMATE PARTNER VIOLENCE POLICY AND IMMIGRATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 2 be adopted.

HOD ACTION: Resolution 2 adopted.

Resolution 2 is concerned with the mandatory reporting laws that exist in the United States. The laws generally mandate a health care professional to report suspected domestic violence. There is concern that undocumented immigrants who are victims of domestic violence may be reluctant to seek medical treatment for fear of being identified to immigration authorities. The resolution asks that the AMA encourage appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care. Furthermore, the resolution asks that the AMA work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status.

Testimony was in support of this resolution. Several noted that this is a vulnerable group who needs protection, and that current AMA policy supports this resolution. Therefore, your Reference Committee recommends that Resolution 2 be adopted.

(5) RESOLUTION 4 - TISSUE HANDLING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 4 be adopted.

HOD ACTION: Resolution 4 adopted.

Resolution 4 is concerned with recent laws that mandate the interment of tissue obtained from the termination of a pregnancy, which is a departure from disposal methods of tissues obtained during other medical procedures. Because this requirement has no scientific basis and has practical implications for patients and physicians, the resolution asks that the AMA adopt policy stating that fetal tissue obtained during the termination of a pregnancy should be handled no differently than tissues obtained during other medical procedures. The resolution further asks that the AMA strongly oppose any proposed laws or regulations that would require the handling of fetal tissue obtained during the termination of a pregnancy differently than tissues obtained during other medical procedures.

Testimony was overwhelmingly supportive of this resolution. A suggestion was made to amend the resolution to add language stating “consistent with AMA policy”, but your Reference Committee recognizes that AMA policy is an ever-changing body of work and this additional language may not be applicable in the future. Your Reference Committee recommends that Resolution 4 be adopted.

(6) **BOARD OF TRUSTEES REPORT 5 - EFFECTIVE PEER REVIEW**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 5 be amended by addition to read as follows:

2. That AMA Policy H-375.962, “Legal Protections for Peer Review,” be amended by addition to read as follows:

...Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in good faith peer review activities. (Modify Current HOD Policy);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be adopted as amended.

HOD ACTION: The recommendations in Board of Trustees Report 5 adopted as amended.

D-375.987 “Effective Peer Review” (adopted I-16) states that “[o]ur AMA study the current environment for effective peer review, on both a federal and state basis, in order to update its current policy to include strategies for promoting effective peer review by physicians and to consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review.” This report responds to that directive, amending appropriate policy where applicable, and directing the AMA to provide guidance, consultation and model legislation concerning protections from retaliation for physician peer review participants, upon request of state medical associations and national medical specialty societies.

Testimony was largely in favor of adopting this report. Those testifying noted that these protections are particularly important as more physicians are employed in hospital systems. An amendment was offered suggesting that language be added to include review of non-physician practitioners. While your Reference Committee recognizes that there are circumstances where physicians are called upon to evaluate the activities of advance practice providers or other non-physician practitioners, this is not true “peer” review and nevertheless may still be covered by the existing language that states “peer review *activities*” (emphasis added). Your Reference Committee also heard testimony related to the addition of language regarding reporting incompetent colleagues or “offending entities”; however, the AMA already has numerous policies which address such reporting (e.g., E-9.4.3 Discipline & Medicine; E-9.4.2 Reporting Incompetent or Unethical Behavior by Colleagues; E-9.3.2 Physician Responsibilities to Impaired Colleagues; H-275.998 Physician Competence; H-375.984 Peer Review). Finally, some testimony

suggested adding “good faith” prior to the term “peer review” where applicable in H-375.962, “Legal Protections for Peer Review” to be consistent with H-225.942 “Physician and Medical Staff Member Bill of Rights” and to emphasize legitimate peer review activities from sham peer review. Your Reference Committee recommends that Board of Trustees Report 5 be adopted as amended.

(7) RESOLUTION 1 – DISAGGREGATION OF DATA CONCERNING THE STATUS OF ASIAN-AMERICANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 1 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support the disaggregation of demographic data regarding Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. (New HOD Policy)

RESOLVED, That our American Medical Association support the disaggregation of demographic data regarding ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 1 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 1 be changed to read as follows:

DISAGGREGATION OF DEMOGRAPHIC DATA WITHIN ETHNIC GROUPS

HOD ACTION: Resolution 1 adopted as amended with a change in title.

Resolution 1 asks that the AMA support the disaggregation of data regarding Asian-Americans in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

Your Reference Committee heard testimony in support of the importance of disaggregating such data as significant disparities exist within subgroups and current data collection practices do not allow capturing of these differences. It was noted that the type of data collection should be clarified, current terminology should be used in reference to ethnic groups, and that other non-Asian ethnic groups should be acknowledged. Additional language was offered to illuminate these points. Therefore your Reference Committee recommends adopting this Resolution 1 as amended.

(8) RESOLUTION 3 - REVISION OF AMA POLICY REGARDING SEX WORKERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 3 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend the text of HOD Policy H-20.898, "Global HIV/AIDS Prevention," by addition and deletion to read as follows:

H-20.898 Global HIV/AIDS Prevention

Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to ~~prostitution sex work the exchange of sex for money or goods~~ (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend the text of HOD Policy H-20.922, "HIV/AIDS as a Global Public Health Priority," by addition and deletion to read as follows:

H-20.922 HIV/AIDS as a Global Public Health Priority

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through ~~prostitutes commercial sex the exchange of sex for money or goods~~;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic.
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend the title and text of HOD Policy H-515.958, "Promoting Safe Exit from Prostitution," by addition and deletion to read as follows:

H-515.958 Promoting Safe Exit from Prostitution ~~Sex Work~~ Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods
 Our American Medical Association supports efforts to offer ~~individuals~~ opportunities ~~to~~ for a safe exit from prostitution ~~the exchange of sex for money or goods~~ ~~sex work~~ safely if ~~they~~ individuals choose to do so, and supports ~~as well as~~ access to in pursuit of compassionate care and “best practices” ~~based~~ services whether or not they choose to continue in sex work. Our American Medical Association also ~~and~~ supports legislation for programs that ~~prevent~~ provide alternatives and resources ~~employment to~~ for individuals who exchange sex for money or goods, choosing to leave sex work and offer alternatives for those ~~to individuals~~ arrested on ~~sex work~~ related charges divert prostitution rather than penalize ~~them~~ it through criminal conviction and incarceration.
 (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 3 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 3 be changed to read as follows:

REVISION OF AMA POLICY REGARDING INDIVIDUALS WHO EXCHANGE SEX FOR MONEY OR GOODS

HOD ACTION: Resolution 3 adopted as amended with a change in title.

Resolution 3 concerns the use of the language “prostitute” and “prostitution”; these terms are now considered pejorative and stigmatizing. The terms “sex worker” and “sex work” are the utilized terms in the medical and public health research communities. Therefore, the resolution asks that the AMA amend HOD Policies H-20.898, H-20.922, and H-515.958 to change all language referring to “prostitution” and “prostitution” to instead be that of “sex worker” and “sex work”.

Supportive testimony was heard on the importance of updating AMA policy (which currently uses outdated and stigmatizing terminology) to reflect current terminology which describes the practice as opposed to labeling the individual. Amendments to the original resolution reflecting this was provided during testimony and supported. Some testimony advocated for the inclusion of the word “adult” to describe those who exchange sex for money or goods, but it was noted that any person younger than age 18 is a person who is being used for sex trafficking and not participating in the consensual exchange of sex for money or goods. Your Reference Committee recommends that Resolution 3 be adopted as amended.

(9) RESOLUTION 7 - GIVING RIGHTS TO ECTOPIC PREGNANCIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 7:

HOD ACTION: The following resolution adopted in lieu of Resolution 7 with a change in title.

RESOLVED, that our AMA oppose any policies that interfere with the patient-physician relationship by giving probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or imposing legislative

barriers to medical decision-making by changes in tax codes or in definitions of beneficiaries.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 7 be changed to read as follows:

POLITICAL INTERFERENCE IN THE PATIENT-PHYSICIAN RELATIONSHIP

Resolution 7 asks that the AMA oppose any policies that give legal rights (such as probate, inheritance, and social security numbers to ectopic and/or molar pregnancies. It also asks that the AMA oppose any personhood measure not based on sound scientific or medical knowledge, or which threatens the safety and effective treatment of patients. Finally, the resolution asks that the AMA oppose any imposition on medical decision-making or the patient-physician relationship by changes in tax codes or in the definitions of beneficiaries.

Substitute language was offered in testimony in order to streamline the intent of the resolution. Subsequent testimony demonstrated significant support of this substitute, including support of the author. As such, your Reference Committee recommends that the substitute resolution be adopted in lieu of Resolution 7.

(10) BOARD OF TRUSTEES REPORT 7 - MEDICAL REPORTING FOR SAFETY-SENSITIVE POSITIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 7 be referred.

HOD ACTION: Board of Trustees Report 7 referred.

Board of Trustees Report 8-I-16, "Medical Reporting for Safety Sensitive Positions," which sought to address Resolution 14-A-16 of the same title, was referred at the 2016 Interim Meeting of the AMA House of Delegates. Testimony indicated that the report content missed the resolution's original intent. Although there are systems in place to screen pilots and others in safety sensitive positions for serious medical conditions, it was stated that these patients often look for medical care outside of these systems, and subsequently fail to be reported. The Board of Trustees conferred with the authors to clarify the intent of Resolution 14-A-16. Board of Trustees Report 7-I-17 creates policy which alerts physicians that they may have new responsibilities as a result of changes in regulations of the FAA regarding medical certification of pilots and addresses the implications of these changes for pilot and public safety.

Testimony regarding this report largely supported referral. Concerns were raised regarding the obligations that the FAA's new "BasicMed" program puts on physicians who are not aviation medical examiners and the lack of knowledge and education that general practitioners have regarding the rules and regulations of aviation licensing. Other issues such as equating mental and physical illnesses, conflicts of interest, and medical liability in particular were raised. Testimony also noted the lack of uniformity of physician reporting of potentially impaired conditions for motor vehicle operators, which may give insight to potential reporting issues for aircraft operators. Finally, your Reference Committee believes that it would be appropriate for the scope of a future report to address other safety sensitive positions such as bus drivers, train engineers, and other similarly situated professionals. Therefore, your Reference Committee recommends that Board of Trustees Report 7 be referred for further study to address these concerns.

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

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 referred.

Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. Council on Ethical and Judicial Affairs Report 1 provides guidance for physicians regarding competence, self-assessment, and self-awareness when practicing medicine.

Your Reference Committee heard mixed testimony on this item. While testimony was supportive of the spirit of the report as an aspirational document, concerns were raised about the ability of physicians to fulfill the recommendations. Your Reference Committee discussed cited data regarding the tenuous nature of "self-awareness" as well as the lack of reliable tools and resources available to assist physicians in self-assessment. It was noted that the House of Delegates would benefit from a scientific analysis of the available data and tools related to this issue. Therefore your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

(12) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 -
SUPPORTING AUTONOMY FOR PATIENTS WITH DIFFERENCES OF
SEX DEVELOPMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 referred.

In response to Resolution 3-A-16 regarding infants born with differences of sex development, this report amends E-2.2.1 Pediatric Decision Making to clarify a physician's responsibility to support a minor's autonomy and right to an open future.

While testimony for this report was largely supportive, concerns were raised regarding the unintended consequences for general pediatric decision-making in addressing the original resolution by amending this ethics opinion. Likewise, the title of the report specifically names differences of sex development but the recommendation is broader, which seemed confusing and problematic and indicates that the concerns raised by the original author were not yet fully addressed. Incidentally, the authors of the resolution indicated that Board of Trustees Report 8-I-16 (of the same title, referred at that meeting) offered a better framework to address their specific concerns. Therefore Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

(13) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 -
MERGERS OF SECULAR AND RELIGIOUSLY AFFILIATED HEALTH
CARE INSTITUTIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 4 referred.

This report responds to D-140.956 which directs the AMA to "conduct a study of access to care in secular hospitals and religiously-affiliated hospitals to include any impact on access to services of consolidation in secular hospital systems and religiously-affiliated hospital systems." The report provides guidance to physicians who are in leadership positions that have or are contemplating a merger.

While testimony regarding this report was largely supportive, your Reference Committee cited several issues. The first recommendation of the report asks to rescind AMA policy D-140.956 which directed this report. However, while the authors of the original resolution appreciated CEJA's ethical analysis on the issue, they are still seeking a study on the effect of hospital mergers on access to care. This could be accomplished by retaining the policy and urging the Council on Medical Service to write a report in response. Further, concern was heard regarding the use of the phrase "at the minimum" in (c), because this does not reflect current market realities. Your Reference Committee suggests that the AMA would benefit from a study of the related access to care issues regarding Recommendation 1, and more consideration given to the concern in (c) by CEJA. Given these concerns, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 be referred.

(14) RESOLUTION 5 - PROTECTION OF PHYSICIAN FREEDOM OF SPEECH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 5 be referred.

HOD ACTION: Resolution 5 referred.

Resolution 5 concerns a physician's First Amendment right to express good faith views on medical therapies and issues. Physicians are increasingly being sued for expression of their views on medical issues, most recently on the expression of views related to treatment of chronic pain and medical marijuana. These lawsuits are expensive, produce anxiety, and are having an impact on physician's willingness to speak out on controversial medical issues. The resolution asks that the AMA strongly oppose litigation challenging the exercise of a physician's First Amendment right to express good faith opinions regarding medical issues. Furthermore, the resolution asks the AMA's House of Delegates encourage the AMA Litigation Center to provide such support to a constituent or component medical society whose members have been sued for expressing good faith opinions regarding medical issues as the Litigation Center deems appropriate in any specific case.

Testimony supported the intent of this resolution; however concerns were raised regarding the use of the term "good faith". Your Reference Committee recognizes that this is a complex and sensitive issue and therefore recommends that Resolution 5 be referred in order to investigate the optimal language needed in order to accomplish the goals of this resolution.

(15) RESOLUTION 6 - PHYSICIANS' FREEDOM OF SPEECH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 6 be referred.

HOD ACTION: Resolution 6 referred.

Resolution 6 addresses a physician's First Amendment right to free speech. Recently, physicians have been disciplined or terminated by their employers for expressing their personal viewpoints on their social media accounts. The resolution asks that the AMA encourage the Council on Ethical and Judicial Affairs to amend Ethical Opinion 1.2.10, "Political Actions by Physicians", by adding in language that physicians should indicate that they are expressing their constitutionally guaranteed personal views, and not that of their employers, and that physicians should be allowed to express their personal opinions without being subjected to disciplinary actions or termination.

Testimony supported the spirit of this resolution; however, concerns were raised regarding the appropriate wording of the additional clauses offered by the author. Your Reference Committee recognizes the complexity of this issue and therefore recommends that Resolution 6 be referred.

REPORT OF REFERENCE COMMITTEE B

(1) BOARD OF TRUSTEES REPORT 6 - ELECTRONICALLY PRESCRIBED CONTROLLED SUBSTANCES WITHOUT ADDED PROCESSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 6 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 6 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following policies be amended and the remainder of the report be filed. That current AMA Policy D-120-956, "Electronic Prescribing and Conflicting Federal Guidelines" Our American Medical Association will continue to advocate before relevant federal and state agencies and legislative bodies for the elimination of address with the Centers for Medicare & Medicaid Services and the Drug Enforcement Administration the contradictory cumbersome, confusing, and burdensome requirements guidance, issued respectively by those two federal agencies, relating to electronic transmission of physicians' controlled substance prescriptions to pharmacies—commonly referred to as "e prescribing" Electronic Prescribing for Controlled Substances (EPCS). This includes for Schedules II, III, IV, and V drugs, as those current guidelines add rather than reduce administrative paperwork and defeat the purpose of electronic handling of prescriptions (Modify Current HOD Policy). That current AMA Policy D-120.958, "Federal Roadblocks to E-Prescribing," Our AMA will initiate discussions work with the Centers for Medicare and Medicaid Services and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs, including removal of the Medicaid requirement in all states that continue to mandate that physicians write, in their own hand, "brand medically necessary" or the equivalent on a paper prescription form. 2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of eE-prescribing. 34. Our AMA will work with the largest and nearly exclusive national electronic pharmacy network, all related state pharmacy regulators, and with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions. 45. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption. 56. Our AMA will: (A) investigate work to substantially reduce regulatory burdens so that physicians may successfully submit electronic prescriptions for controlled substances; and (B) work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply.67. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications. 78. Our AMA will petition work with the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions for prescription drugs or to temporarily halt the e prescribing requirements of meaningful use until this is accomplished (Modify Current HOD Policy) That current AMA Policy H-120.957, "Prescription of Schedule II Medications by Fax and Electronic Data Transmission," Our AMA: (1) encourages the Drug Enforcement Administration to rewrite Section 1306 of Title 21 of the Code of Federal Regulations to support two factor authentication that is easier to implement than the current DEA and EPCS security requirements accommodate encrypted electronic prescriptions for Schedule II controlled substances, as long as sufficient security measures are in place to ensure the

~~confidentiality and integrity of the information. (2) Our AMA supports the concept that public key infrastructure (PKI) systems or other signature technologies designed to accommodate electronic prescribing should be readily adaptable to current computer systems, and should satisfy the criteria of privacy and confidentiality, authentication, incorruptibility, and. (23) Because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, the AMA does not support the use of "hard copy" facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations (Modify Current HOD Policy).~~

Your Reference Committee heard supportive testimony on Board Report 6. Your Reference Committee strongly agrees that the current Administration should take immediate steps to facilitate e-prescribing of controlled substances as detailed in the Board Report in order to curb diversion of opioids and other controlled substances as well as to streamline administrative paperwork burdens and to improve patient compliance and outcomes. Therefore, your Reference Committee recommends adoption of the Recommendations in Board Report 6 and that the remainder of the report be filed.

(2) RESOLUTION 215 - RELIEVE BURDEN FOR LIVING ORGAN DONORS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 215 be adopted.

HOD ACTION: Resolution 215 adopted.

Resolution 215 asks that our American Medical Association amend Policy, H-370.965, "Removing Financial Barriers to Living Organ Donation," by addition and deletion as follows: Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (1) provisions for expenses involved in the donation incurred by the organ donor, (2) providing access to health care coverage for any medical expense related to the donation, (3) prohibiting employment discrimination on the basis of living donor status, and (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage, and (5) provisions to encourage paid leave for organ donation (Modify Current HOD Policy); and be it further that our AMA support legislation expanding paid leave for organ donation. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony for Resolution 215. Your Reference Committee heard testimony that direct costs to living organ donors can be significant and it is critical to relieve the financial burden on donors. Your Reference Committee believes that adoption of the resolution would be consistent with current AMA policy to encourage removing financial barriers to living organ donation and on paid sick leave. Accordingly, your Reference Committee recommends adoption of Resolution 215.

(3) RESOLUTION 216 - RELATIONSHIP WITH THE U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

RECOMMENDATION:

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

HOD ACTION: Resolution 216 adopted.

Resolution 216 asks that our American Medical Association continue to consider and implement the most strategic and sustainable approaches to collaborate and engage with the US Department of Health and Human Services to: (1) advance and advocate for policies of importance to physicians and patients; (2) promote physician leadership in emerging health care organizational and reimbursement structures; and (3) enhance the opportunity for physician input. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 216. Your Reference Committee heard that our AMA is already doing significant work to advocate and advance policies of importance to physicians. Your Reference Committee also heard testimony that the AMA should continue to publicize the advocacy efforts it is taking on behalf of its members and the public. Your Reference Committee believes that our AMA should and will continue to engage with the U.S. Department of Health and Human Services to advance key policies for physicians, promote physician leadership in emerging health care structures, and enhance the opportunity for physician input. Therefore, your Reference Committee recommends adoption of Resolution 216.

(4) RESOLUTION 217 - REGULATIONS REGARDING MEDICAL TOOL AND INSTRUMENT REPAIR

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 217 be adopted.

HOD ACTION: Resolution 217 adopted.

Resolution 217 asks that our American Medical Association strongly oppose any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 217 that oversight and regulation of medical devices, medical tools, and instrument repairs should be based on objective scientific data. Your Reference Committee agrees that additional oversight or oversight modernization should be based on sound evidence of associated benefit and risk. Therefore, your Reference Committee recommends adoption of Resolution 217.

(5) RESOLUTION 222 - APPROPRIATE USE OF OBJECTIVE TESTS FOR OBSTRUCTIVE SLEEP APNEA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 222 be adopted.

HOD ACTION: Resolution 222 adopted.

Resolution 222 asks that it be the policy of our American Medical Association that: (1) ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring constitutes the practice of medicine; (2) the need for, and appropriateness of, objective tests for purposes of diagnosing OSA or primary snoring or evaluating treatment efficacy must be based on the patient's medical history and examination by a licensed physician; and (3) objective tests for diagnosing OSA and primary snoring are medical assessments that must be ordered and interpreted by a licensed physician. (New HOD Policy)

Your Reference Committee heard limited but uniformly supportive testimony on Resolution 222. Your Reference Committee strongly agrees that a home sleep apnea test is a medical assessment that is inappropriate and dangerous for patient care to be ordered by a non-physician and used without physician oversight. Your Reference Committee also heard that the Council on Legislation as well as the Council on Medical Service would welcome advocacy in this area. Therefore, your Reference Committee recommends that Resolution 222 be adopted.

(6) RESOLUTION 225 - OPPOSE INCLUSION OF MEDICARE PART B DRUGS IN QPP/MIPS PAYMENT ADJUSTMENT

RECOMMENDATION:

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

HOD ACTION: Resolution 225 adopted.

Resolution 225 asks that our American Medical Association continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the Merit-Based Incentive Payment System (MIPS) payment adjustment as part of the Quality Payment Program (QPP). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 225. Your Reference Committee heard testimony that our AMA has existing policy, H-385.911, which asks our AMA to work with Congress and Centers for Medicare and Medicaid Services (CMS) to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms. In addition, your Reference Committee heard testimony that based on existing policy, our AMA has advocated Congress and CMS to remove Medicare Part B drugs from the Merit-Based Incentive Payment System (MIPS) payment adjustments. However, your Reference Committee also heard testimony that current AMA policy focuses on the removal of Medicare Part B drugs from the MIPS payment adjustment, and should be expanded to include the removal of Medicare Part B drugs from the calculation of physicians' cost performance category score. Therefore, your Reference Committee recommends adoption of Resolution 225.

(7) RESOLUTION 230 - OPPOSE PHYSICIAN ASSISTANT INDEPENDENT PRACTICE

RECOMMENDATION:

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

HOD ACTION: Resolution 230 adopted.

Resolution 230 asks that our American Medical Association adopt policy to oppose legislation or regulation that allows physician assistant independent practice. (New HOD Policy)

Your Reference Committee heard overwhelming testimony in support of Resolution 230. Your Reference Committee heard great concern that recent changes to physician assistant policy threaten to transform and further fragment the physician-led team model of care. Your Reference Committee also heard testimony clearly stating that it is inappropriate for physician assistants to practice without physician supervision, collaboration, or oversight. Your Reference Committee also heard testimony for the need to add this and other physician assistant scope of practice issues to the in-person meeting addressed subsequently in Item 14 of this report (Resolution 214). Instead of duplicating language here, your Reference Committee feels that the language proffered in Resolution 214 is sufficient to ensure inclusion of the issues at the in-person meeting. Your Reference Committee agrees that this Resolution provides a timely and necessary addition to AMA policy, and accordingly, recommends that Resolution 230 be adopted.

(8) RESOLUTION 231 - ELECTRONIC PRESCRIPTION CANCELLATION

RECOMMENDATION:

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

HOD ACTION: Resolution 231 adopted.

Resolution 231 asks that our American Medical Association support the creation, standardization, and implementation of electronic prescription cancellation from all electronic medical records vendors and that these orders be accepted by pharmacies and pharmacy benefit managers. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 231. Your Reference Committee heard testimony promoting the use of electronic prescription cancellations to facilitate a more efficient system with fewer medication errors. Your Reference Committee also heard testimony that this Resolution builds on existing AMA policy on electronic prescribing and electronic medical records. Therefore, your Reference Committee recommends adoption of Resolution 231.

(9) RESOLUTION 220 - PRESERVING PROTECTIONS OF THE AMERICANS WITH DISABILITIES ACT OF 1990

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve in Resolution 220 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-90.971 be reaffirmed in lieu of the second Resolve in Resolution 220.

HOD ACTION: Resolution 220 adopted with addition of a third Resolve.

RESOLVED, That our AMA develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act (ADA) as well as any applicable state laws.

Resolution 220 asks that That our American Medical Association support legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability (New HOD Policy); and be it further that our AMA oppose legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 220. Strong testimony was presented in favor of adopting the first Resolve that would, in part, amend the American with Disabilities Act (ADA) to require the Department of Justice to develop a program to educate state and local governments and property owners on strategies for promoting access for persons with a disability. Conflicting testimony was presented on the second Resolve. While your Reference Committee agrees “notice and cure” requirements could delay access to the courts for individuals with a disability to challenge violations of the ADA, your Reference Committee is also concerned with adopting policy that could potentially result in meritless lawsuits against physicians. Your Reference Committee also believes that existing policy already covers the goal of the second Resolve. Accordingly, your Reference Committee recommends adoption of the first Resolve and reaffirmation of H-90.971, Enhancing Accommodations for People with Disabilities, in lieu of adoption of the second Resolve.

H-90.971, Enhancing Accommodations for People with Disabilities

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

(10) RESOLUTION 202 - SEXUAL ASSAULT SURVIVORS' RIGHTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 202 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are

not limited to, the right to: (1) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (2) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (3) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (4) be informed of these rights and the policies governing the sexual assault evidence kit; and (5) access to emergency contraception information and treatment for pregnancy prevention. (New HOD Policy);

RECOMMENDATION B:

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

HOD ACTION: Resolution 202 adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policy H-80.998 be amended by addition and deletion to read as follows:

Rape Victim H-80.998 Sexual Assault Survivor Services

The AMA supports the function and efficacy of rape victim sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages rape sexual assault crisis centers to continue working with local police to help rape victims sexual assault survivors, and encourages physicians to support the option of having a rape victim counselor present while the victim sexual assault survivor is receiving medical care.

HOD ACTION: Policy H-80.998 amended by addition and deletion to read as follows:

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Policy H-80.999 be amended by addition and deletion to read as follows:

HOD ACTION: Policy H-80.999 amended by addition and deletion to read as follows:

Rape Victims H-80.999 Sexual Assault Survivors

Our AMA supports the preparation and dissemination of information, and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to rape victims sexual assault survivors.

Resolution 202 asks that our American Medical Association advocate for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (1) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (2) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (3) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (4) be informed of these rights and the policies governing the sexual assault evidence kit (New HOD Policy); and be it further that our AMA collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016. (Directive to Take Action)

Your Reference Committee heard broad support for the intent and goals of Resolution 202. Testimony was strongly in favor of the sexual assault survivor protections established by the Survivors' Bill of Rights Act of 2016. Your Reference Committee agrees with testimony that the list of sexual assault survivors' rights ought to include the access to emergency contraception information and treatment for pregnancy prevention. This inclusion is consistent with existing AMA policy. Your Reference Committee also agrees with the testimony urging the amendment of existing policy allowing for changing circumstances as technology, public policy, and treatment for sexual assault survivors evolves. As a result, your Reference Committee recommends that Resolution 202 be adopted as amended and that AMA Policies H-80.998 and H-80.999 be adopted as amended.

(11) RESOLUTION 204 - EHR VENDORS RESPONSIBLE FOR HEALTH INFORMATION TECHNOLOGY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that physicians are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards. (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services (CMS) to require Electronic Health Record (EHR) vendors, offering technology for physician use, meet all current certification requirements as approved by the ONC's Health IT Certification Program (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that EHR vendors, not physicians, not be financially penalized for certified EHR technology not meeting current standards. (New HOD Policy)

RECOMMENDATION C:

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

HOD ACTION: Resolution 204 adopted as amended.

Resolution 204 asks that our American Medical Association petition the Centers for Medicare and Medicaid Services (CMS) to require Electronic Health Record (EHR) vendors, offering technology for physician use, meet all current certification requirements as approved by the ONC's Health IT Certification Program (Directive to Take Action); and be it further that our AMA advocate that EHR vendors, not physicians, be financially penalized for EHR technology not meeting current standards. (New HOD Policy)

Your Reference Committee heard generally supportive testimony for Resolution 204. Your Reference Committee heard testimony that physicians should not be penalized for EHR software defects and failure to maintain certification because physicians have no control over this process. Testimony was also given that the first Resolve is unnecessary because CMS already requires this certification. Your Reference Committee also heard testimony that Resolution 204 should provide flexibility to our AMA because this issue is ongoing with different programs and

certifications. Therefore, your Reference Committee recommends that Resolution 204 should be amended to support the approach that our AMA has historically taken and found to be successful.

(12) RESOLUTION 206 - DEFENDING FEDERAL CHILD NUTRITION PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose legislation and regulatory initiatives that reduces or eliminates access to federal child nutrition programs.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

Resolution 206 asks that our American Medical Association oppose legislation that reduces or eliminates access to federal child nutrition programs (New HOD Policy); and be it further that our AMA reaffirm Policy H-150.962, “Quality of School Lunch Program.” (Reaffirm HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 206. Your Reference Committee agrees with testimony presented that, while our AMA has numerous policies related to nutrition for children in general and related specifically to standards for school meals and snacks, our AMA does not have policy covering efforts to reduce or eliminate federal child nutrition programs. Your Reference Committee believes that adoption of this resolution would be a positive addition to our AMA policy base. Your Reference Committee heard testimony recommending that the first Resolve could be strengthened by adding a reference to “regulatory initiatives.” Your Reference Committee agrees and therefore recommends that Resolution 206 be adopted as amended.

(13) RESOLUTION 209 - GOVERNMENT MANDATED SEQUESTER

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 209 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate to remove the sequester provision for Part B Medicare reimbursement.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 209 be adopted as amended.

HOD ACTION: Resolution 209 adopted as amended.

Resolution 209 asks that our American Medical Association advocate to remove the sequester provision for Part B Medicare reimbursement. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 209. Many commenters agreed with the intent of this Resolution. Your Reference Committee heard supportive testimony that our AMA has previously engaged in

advocacy on this issue and should continue to oppose the sequester. However, your Reference Committee also heard testimony that the Resolution should be amended to include all Medicare reimbursement affected by sequestration cuts, not just Medicare Part B reimbursement. Your Reference Committee agrees that Resolution 209 should be amended to include all Medicare reimbursement. Therefore, your Reference Committee recommends that Resolution 209 be adopted as amended.

(14) RESOLUTION 214 - ADVANCED PRACTICE REGISTERED NURSE COMPACT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 214 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association convene an in-person meeting of relevant physician stakeholders to initiate a national strategy to address the APRN (Advanced Practice Registered Nurses) Compact: creation of a consistent national strategy (consensus principles of agreement/solutions, model legislation, national and state public relations campaigns) purposed to: (1) Effectively oppose the continual, nationwide efforts to grant independent practice (e.g., APRN Consensus Model, APRN Compact) to non-physician practitioners (APRN, physician assistant, Doctor of Medical Science, Advance Practice Respiratory Therapists, etc.); (2) Effectively educate the public, legislators, regulators, and healthcare administrators; and (3) Effectively oppose state and national level legislative efforts aimed at inappropriate scope of practice expansion of non-physician healthcare practitioners; with report back at the 2018 Annual Meeting. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted as amended.

HOD ACTION: Resolution 214 adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that AMA Policy H-35.988 be amended by addition and deletion to read as follows:

HOD ACTION: AMA Policy H-35.988 amended by addition and deletion to read as follows:

H-35.988, Independent Practice of Medicine by "Nurse Practitioners" Advanced Practice Registered Nurses

The Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

Resolution 214 asks that our American Medical Association convene an in-person meeting of relevant stakeholders to initiate a national strategy to address the APRN (Advanced Practice Registered Nurses) Compact. (Directive to Take Action)

Your Reference Committee heard strong and nearly unanimous testimony in support of the intent of Resolution 214. Your Reference Committee heard strong testimony in opposition to the independent practice of advanced practice nurses (APRNs) and the APRN Multistate Compact (APRN Compact), which would allow APRNs with a multistate license to practice without supervision, collaboration, or oversight in any APRN Compact state. Since 2016, the APRN Compact has been enacted in three states and has yet to reach the threshold of 10 states necessary for the Compact to activate.

Your Reference Committee agrees that the original language of Resolution 214 needs to be strengthened. Your Reference Committee believes that the recommendation offered by the Council on Legislation, to amend existing AMA Policy H-35.988 to include AMA opposition to the APRN Compact, accomplishes that goal.

Your Reference Committee also heard overwhelming testimony in support of an AMA convened in-person meeting of relevant physician stakeholders to initiate creation of a consistent national strategy purposed to (1) effectively oppose the continual, nationwide efforts to grant independent practice (e.g., APRN Consensus Model, APRN Compact) to non-physician practitioners (APRN, physician assistant, Doctor of Medical Science, Advance Practice Respiratory Therapists, etc.); (2) effectively educate the public, legislators, regulators and healthcare administrators; and (3) effectively oppose state and national level legislative efforts aimed at inappropriate scope of practice expansion of non-physician healthcare practitioners. Your Reference Committee will note that this meeting should include the issues raised in Resolutions 229 and 230 related to physician assistant scope of practice and indicated as such in our discussions related to these resolutions as well. Your Reference Committee, therefore, recommends that Resolution 214 be adopted as amended and that AMA Policy H-35.988 be amended.

(15) RESOLUTION 223 - TREATING OPIOID USE DISORDER IN CORRECTIONAL FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 223 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy in conjunction with counseling, in correctional facilities within the United States and that this apply to all incarcerated individuals including pregnant women. (New HOD Policy)

RECOMMENDATION B:

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

RESOLVED, That our AMA support legislation, standards, policies, and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment providers physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including pregnant women, are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths and help ensure post-incarceration medical coverage and accessibility to medication assisted therapy. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that a Resolution 223 be adopted as amended.

HOD ACTION: Resolution 223 adopted as amended.

Resolution 223 asks that our American Medical Association advocate for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy, in correctional facilities within the United States (New HOD Policy); and be it further that our AMA support legislation, standards, policies and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment providers, case managers, social workers, and pharmacies in the communities where patients are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment, and medication for preventing overdose deaths. (New HOD Policy)

Your Reference Committee heard strong support for ensuring patients have access to evidence-based treatment for opioid use disorder whether in prison, upon release from prison, and continuing beyond the initial entry or release. Your Reference Committee heard testimony that called for substituting the term “provider” with “physician-led teams,” as well as testimony that noted the need for initiation and continuation of opioid replacement therapy to be in conjunction with counseling. Finally, we also heard that pregnant women are often overlooked in this debate and therefore, need to be explicitly identified in Resolution 223. For these reasons, your Reference Committee recommends that Resolution 223 be adopted as amended.

(16) RESOLUTION 224 - MODERNIZING PRIVACY REGULATIONS FOR ADDICTION TREATMENT RECORDS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association ~~seek support~~ 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 (Directive to Take Action); and be it further

RECOMMENDATION B:

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

RESOLVED, That our AMA ~~seek support~~ 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 (Directive to Take Action); and be it further

RECOMMENDATION C:

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

HOD ACTION: Resolution 224 adopted as amended.

Resolution 224 asks that our American Medical Association seek 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 (Directive to Take Action); and be it further that our AMA seek 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 (Directive to Take Action); and be it further

that our AMA support continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 224. Your Reference Committee heard there is a need to establish a better balance between the privacy rights of patients with substance use disorders and the need for health professionals treating such patients to be fully informed about their patients' medical background, including whether they have a history of, or are currently being treated for, substance use disorders. Your Reference Committee also heard support for an amendment to change the directive in resolues one and two from "seek" to "support." Your Reference Committee believes that a slight modification to the language in resolues one and two would clarify the directives to our AMA. Therefore, your Reference Committee recommends adoption of Resolution 224 as amended.

(17) RESOLUTION 227 - COMMUNICATION AND RESOLUTION PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 227 be amended by addition and deletion to read as follows.

RESOLVED, That our American Medical Association ~~urgently research support early the~~ Communication and Resolution Programs as a viable option to settle disputes, prior to litigation. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 227 be adopted as amended.

HOD ACTION: Resolution 227 adopted as amended.

Resolution 227 asks that our American Medical Association urgently research the Communication and Resolution Program as a viable option to settle disputes, prior to litigation. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 227. Your Reference Committee agrees with testimony presented that early communication and resolution programs are an effective way to learn from medical errors and near misses, enhance patient safety, and improve the liability system. Your Reference Committee also heard that multiple studies have already shown the benefits of this early communication and that our AMA does not need to conduct a study to demonstrate effectiveness. Therefore, your Reference Committee recommends that Resolution 227 be amended and adopted to demonstrate our AMA's support of early communication and resolution programs.

(18) RESOLUTION 229 - OPPOSITION TO LICENSING FOR INDIVIDUALS HOLDING DEGREE OF DOCTOR OF MEDICAL SCIENCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~develop model legislation for states that would~~ oppose the holders of the degree of Doctor of Medical Science from being recognized as a new category of health care practitioners licensed for the independent practice of medicine, and work with interested state medical associations and national medical specialty societies to oppose legislation to create a Doctor of Medical Science license. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 229 be adopted as amended.

HOD ACTION: Resolution 229 adopted as amended.

Resolution 229 asks that our American Medical Association develop model legislation for states that would oppose the holders of the degree of Doctor of Medical Science from being recognized as a new category of health care practitioners licensed for the independent practice of medicine. (Directive to Take Action)

Your Reference Committee heard testimony overwhelmingly in support of the spirit of this resolution and in opposition to legislation that would create a Doctor of Medical Science (DMS), an advanced physician assistant degree that would allow these practitioners to practice independently. Your Reference Committee heard that our AMA, through its Advocacy Resource Center, has been working to educate our Federation partners, including state and specialty societies, about this new proposal, and has been working hand-in-hand with the medical associations in those states that have considered DMS legislation. This work has led to the defeat of every piece of DMS legislation proposed so far. Testimony strongly suggested that continuing this work is a more appropriate and effective course of action than developing model legislation to prohibit the DMS, and that introduction of preventive model legislation may in fact bring more attention to the DMS than is warranted. Your Reference Committee agrees with the proposed amendment proffered by the Council on Legislation to that effect. Your Reference Committee also heard testimony for the need to add this and other physician assistant scope of practice issues to the in-person meeting addressed earlier in our discussion of Item 14 (Resolution 214). Instead of duplicating language here, your Reference Committee feels that the language proffered in Resolution 214 is sufficient to ensure inclusion of the issues at the in-person meeting. As such, your Reference Committee recommends that Resolution 229 be adopted as amended.

(19) RESOLUTION 232 - PRESENCE AND ENFORCEMENT ACTIONS ON IMMIGRATION AND CUSTOMS ENFORCEMENT IN HEALTHCARE FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the fourth Resolve be amended by addition as follows:

RESOLVED, That our AMA oppose the presence of ICE enforcement at healthcare facilities in non-exigent circumstances. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Resolution 232 adopted.

Resolution 232 asks that our American Medical Association advocate for and support legislative efforts to designate healthcare facilities as sensitive locations by law (New HOD Policy); and be it further, that our AMA work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur (Directive to Take Action); and be it further, that our AMA encourage healthcare facilities to clearly demonstrate and promote their status as sensitive locations (New HOD Policy); and be it further, that our AMA oppose the presence of ICE enforcement at healthcare facilities. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 232. Your Reference Committee heard testimony that ICE enforcement actions in medical facilities disrupt the physician-patient relationship and threaten public

safety. Testimony further stated that it is important for both health care providers and their patients to know their legal rights when encountering law enforcement and ICE agents. Your Reference Committee also heard that the fourth Resolve is too broad and does not account for circumstances where ICE might have a legitimate reason to be present at health care facilities, such as in the interest of national security or if other law enforcement actions have led officers to a medical facility. Therefore, your Reference Committee recommends amending Resolution 232 to reflect these concerns.

(20) RESOLUTION 233 - PHARMACISTS CANNOT AND SHOULD NOT BE MAKING MEDICAL DECISIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-120.947 and D-35.981 be reaffirmed in lieu of the first Resolve.

RECOMMENDATION B:

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

RESOLVED, That our AMA work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine, and (b) prohibit pharmacy actions that are unilateral medical decisions seek out those bodies overseeing the nation's pharmacies and advocate that actions be taken to prohibit pharmacists from making medical decisions outside the scope of their practice; (Directive to Take Action) and be it further

RECOMMENDATION C:

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

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 233 be changed to read as follows:

EVALUATING ACTIONS BY PHARMACY BENEFIT MANAGER AND PAYER POLICIES ON PATIENT CARE

HOD ACTION: Resolution 233 adopted as amended with a change in title.

Resolution 233 asks that our American Medical Association (AMA) take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered. (Directive to Take Action); and be it further, that our AMA seek out those bodies overseeing the nation's pharmacies and advocate that actions be taken to prohibit pharmacists from making medical decisions outside the scope of their practice; (Directive to Take Action) and be it further, that our AMA report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination at A-18. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 233. Your Reference Committee heard testimony that implementing policies to restrict prescriptions without any regulatory notice or comment is a concern with all pharmacy benefit managers and payers. Your Reference Committee also heard that we need to have increased scrutiny on behalf of patients to evaluate the actions by Pharmacy Benefit Managers and payers. In order to address

these concerns, your Reference Committee heard testimony that our AMA should work with all relevant stakeholders to discuss these issues and how they impact patient access to care. Furthermore, testimony stated that our AMA already has strong policy regarding the filling of prescriptions as ordered by physicians. Therefore, your Reference Committee recommends that the existing policy be reaffirmed in lieu of the first Resolve, that the second Resolve be adopted as amended, that the third Resolve be adopted, and that the title of Resolution 233 be changed.

H-120.947 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled

1. Our AMA reaffirms our policies supporting responsibility to the patient as paramount in all situations and the principle of access to medical care for all people; and supports legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain should return the prescription to the patient and notify the prescribing physician of the referral.
2. Our AMA supports the concept of advance prescription for emergency contraception for all women in order to ensure availability of emergency contraception in a timely manner.

D-35.981 AMA Response to Pharmacy Intrusion Into Medical Practice

1. Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses and treatment plans to be an interference with the practice of medicine and unwarranted.
2. Our AMA will work with pharmacy associations such as the National Association of Chain Drug Stores to engage with the Drug Enforcement Administration, the federal Department of Justice, and other involved federal regulators and stakeholders, for the benefit of patients, to develop appropriate policy for pharmacists to work with physicians in order to reduce the incidence of drug diversion and inappropriate dispensing.
3. If the inappropriate pharmacist prescription verification requirements and inquiry issues are not resolved promptly, our AMA will advocate for legislative and regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and legitimate therapeutic treatments to patients.

(21) RESOLUTION 235 – AMA ADVOCACY EFFORTS FOR EMERGENCY MEDICAID FUNDING AND ASSISTANCE – PUERTO RICO

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 235 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association urge and advocate the U.S. Congress to quickly pass legislation to adequately fund Puerto Rico's and the U.S. Virgin Island's Medicaid Programs of roughly \$1.6 billion over five years (Directive to Take Action); and be it further,

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that second Resolve of Resolution 235 be amended by addition to read as follows:

RESOLVED, That our AMA urge and advocate for the Centers for Medicare and Medicaid Services to implement temporary emergency regulatory Medicare and Medicaid funding waivers to help restore access to health care services in Puerto Rico and the U.S. Virgin Islands.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 235 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 235 be changed to read as follows:

AMA ADVOCACY EFFORTS FOR EMERGENCY MEDICAID FUNDING AND ASSISTANCE – PUERTO RICO AND THE U.S. VIRGIN ISLANDS

HOD ACTION: Resolution 235 adopted as amended with a change in title.

Resolution 235 asks that the American Medical Association urge and advocate the U.S. Congress to quickly pass legislation to fund Puerto Rico's Medicaid Program of roughly \$1.6 billion over five years (Directive to Take Action); and be it further, that our AMA urge and advocate for the Centers for Medicare and Medicaid Services to implement temporary emergency regulatory Medicare and Medicaid funding waivers to help restore access to health care services in Puerto Rico. (Directive to Take Action).

Your Reference Committee heard overwhelmingly supportive testimony of Resolution 235. Your Reference Committee heard testimony that federal funding for Puerto Rico's Medicaid program provides support for the medical and public health needs of its residents in the aftermath of Hurricanes Irma and Maria. Your Reference Committee also heard testimony that the U.S. Virgin Islands should also be included in providing additional Medicaid funding. Your Reference Committee further heard testimony that removing specific dollar figures from the first Resolve would provide our AMA with flexibility to support funding of Puerto Rico's and the U.S. Virgin Islands' Medicaid programs. Therefore, your Reference Committee recommends amending and changing the title of Resolution 235.

(22) **RESOLUTION 236 - PRESERVING TAX DEDUCTIBILITY OF STUDENT LOAN INTEREST PAYMENTS AND HIGH MEDICAL EXPENSES**

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association immediately and strongly urge Congress to preserve the tax deductibility of student loan interest payments ~~and high medical expenses~~ in any tax reform legislation ~~that will be considered and voted on by the House and Senate~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 236 be amended by addition of a second Resolve to read as follows:

RESOLVED, That our American Medical Association immediately and strongly urge Congress to preserve the tax deductibility of high medical expenses in any tax reform legislation.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 236 be amended by addition of a third Resolve to read as follows:

RESOLVED, That our American Medical Association immediately and strongly urge Congress to maintain the tax-exempt status of tuition waivers and relevant scholarships in any tax reform legislation.

RECOMMENDATION D:

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

HOD ACTION: Resolution 236 adopted as amended.

Resolution 236 asks that our American Medical Association will immediately and strongly urge Congress to preserve the tax deductibility of student loan interest payments and high medical expenses in any tax reform legislation that will be considered and voted on by the House and Senate. (Directive to Take Action)

Your Reference Committee heard strong support for Resolution 236. Your Reference Committee heard testimony that potential changes to the tax code could have an adverse effect on medical students, residents, and practicing physicians in student debt and also adversely affect patients in need of extended medical care. Your Reference Committee heard testimony that our AMA should also advocate to maintain tuition waivers and scholarships in any tax reform legislation. For clarification purposes, your Reference Committee split Resolution 236 with amendments into three separate Resolve clauses. Therefore, your Reference Committee recommends that Resolution 236 is adopted as amended.

(23) **RESOLUTION 201 - IMPROVING FDA EXPEDITED APPROVAL PATHWAYS**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 201 be referred.

HOD ACTION: Resolution 201 referred.

Resolution 201 asks that our American Medical Association work with U.S. Food and Drug Administration (FDA) and other interested stakeholders to design and implement via legislative action (including ensuring appropriate FDA staffing) a process by which drugs which obtain FDA approval via the Fast Track, Accelerated Approval, or Breakthrough Therapy pathways be granted FDA approval on a temporary basis not to exceed 5 years, pending further evidence of safety and efficacy that is at the level set for the standard drug approval process (Directive to Take Action); and be it further that our AMA work with the FDA and other interested stakeholders in improving the process by which drugs are selected for the expedited pathway to improve the prevalence of these drugs that are classified as “specialty drugs.” (Directive to Take Action)

Your Reference Committee heard testimony that was supportive of the goals of Resolution 201. Your Reference Committee also heard testimony that this issue may require further study, including addressing outstanding questions on the relative merit of the four different programs that offer flexibility to expedite drugs. Your Reference Committee strongly believes that it is essential to conduct research and gather additional information on the relative benefits and costs associated with each program and the overall outcomes of each program before congressional or regulatory efforts are initiated. Therefore, your Reference Committee recommends referral of Resolution 201 for report.

(24) **RESOLUTION 203 - BIDIRECTIONAL COMMUNICATION FOR EHR SOFTWARE AND PHARMACIES**
RESOLUTION 205 - HEALTH PLAN, PHARMACY, ELECTRONIC HEALTH RECORDS INTEGRATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 203 and 205 be referred with a report back at the 2018 Annual Meeting.

HOD ACTION: Resolutions 203 and 205 referred with a report back at the 2018 Annual Meeting.

Resolution 203 asks that our American Medical Association engage the American Pharmacy Association, and any other relevant stakeholders, to encourage both Electronic Health Record (EHR) and pharmacy software vendors to have bidirectional communication for an accurate and current medication list in the patient's EHR. (New HOD Policy)

Resolution 205 asks that our American Medical Association advocate that health plans, pharmacies, and EHR vendors integrate their technology programs so that physicians have current and real time access to covered medications for patients within a specific health plan (New HOD Policy); and be it further that our AMA advocate that health plans make patient cost information readily available via this technology so that physicians and their patients may work together to choose the most cost-effective medically appropriate medication for patient care. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolutions 203 and 205. Testimony in support of Resolutions 203 and 205 stated that real-time benefit checks are already being incorporated into some EHRs; however, this development needs to ensure accurate and current communication. Your Reference Committee also heard testimony about the importance of multidirectional communications and that this communication should include both prescription drugs and vaccinations. Your Reference Committee also heard testimony that a substantially similar resolution was referred for report back at Annual 2018 (219-A-17). Your Reference Committee believes that this issue would benefit from further study into feasibility and current practices, as well as potential implications on physician practice. Therefore, your Reference Committee recommends that Resolutions 203 and 205 be referred for report back at Annual 2018 with Resolution 219-A-17.

(25) **RESOLUTION 207 - REDISTRIBUTION OF UNUSED PRESCRIPTION DRUGS TO PHARMACEUTICAL DONATION AND REUSE PROGRAMS**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 207 be referred with a report back at the 2018 Annual Meeting.

HOD ACTION: Resolution 207 referred with a report back at the 2018 Annual Meeting.

Resolution 207 asks that our American Medical Association work with appropriate stakeholders to draft and promote model legislation aimed at developing better funding for drug donation programs on the state level provided these programs follow the quality assurance guidelines set by existing AMA Policy H-280.959. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 207. Your Reference Committee heard testimony about the need to help ensure safe storage and disposal of unused and unwanted medications. Your Reference Committee also heard testimony that a substantially similar resolution was referred to our AMA Board of Trustees for a report due back at the 2018 Annual Meeting (Resolution 525-A-17). Your Reference Committee agrees that the issues raised by Resolution 207 should be included in this report. Therefore, your Reference Committee recommends that Resolution 207 be referred for report back at the 2018 AMA Annual Meeting with Resolution 525-A-17.

(26) **RESOLUTION 208 - INCREASED USE OF BODY-WORN CAMERAS BY LAW ENFORCEMENT OFFICERS**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 208 be referred.

HOD ACTION: Resolution 208 referred.

Resolution 208 asks that our American Medical Association advocate for legislative, administrative, or regulatory measures to expand funding for (1) the purchase of body-worn cameras and (2) training and technical assistance required to implement body-worn camera programs. (New HOD Policy)

Your Reference Committee heard testimony largely in support of referral of Resolution 208. Some testified that the use of body-worn cameras by law enforcement officers was a matter of public health and directly related to existing AMA policy concerning the health of minorities. Others expressed concern that the issues being raised were outside of the expertise and scope of our AMA. In order to address all concerns raised and recognizing the complexity and sensitivity of the issues discussed, your Reference Committee recommends that Resolution 208 be referred.

(27) RESOLUTION 211 - EXCLUSIVE STATE CONTROL OF METHADONE CLINICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 211 be referred.

HOD ACTION: Resolution 211 referred.

Resolution 211 asks that our American Medical Association support complete state control of all aspects of methadone clinic approval and operations; and, if deemed necessary, this control could be granted on a state by state basis. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 211 which was largely in support of referral. Your Reference Committee heard testimony that there is likely both a state and federal role as it relates to methadone clinic approval and operations. Your Reference Committee also acknowledges nearly unanimous testimony that part of this further study needs to include an assessment and recommendations related to methadone clinic reporting (or lack thereof) to state prescription drug monitoring programs. Your Reference Committee agrees that because of the complexity of the issues raised, further study is needed. Your Reference Committee therefore recommends that Resolution 211 be referred.

(28) RESOLUTION 213 - BARRIERS TO PRICE TRANSPARENCY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-155.987 be reaffirmed in lieu of the first Resolve of Resolution 213.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Policies H-155.958 and H-380.994 be reaffirmed in lieu of the second Resolve of Resolution 213.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 213 be referred.

HOD ACTION: Policy D-155.987 reaffirmed in lieu of the first Resolve of Resolution 213, Policies H-155.958 and H-380.994 reaffirmed in lieu of the second Resolve of Resolution 213 and the third Resolve of Resolution 213 referred.

Resolution 213 asks that our American Medical Association work with states and state medical societies to reduce health insurance contract provisions or gag clauses that restrict disclosure of pricing information to patients (Directive to Take Action); and be it further that our AMA work with states and state medical societies to ensure that health insurance contracts do not prohibit the application of discounts to uninsured or under-insured patients if

such discounts are compliant with federal anti-kickback statutes (Directive to Take Action); and be it further that our AMA support access to real-time prescription drug pricing and cost transparency at the point of prescribing. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 213 goals to promote transparency including drug price costs at the point of care and patient access to prescription drug discounts that do not violate federal law. Your Reference Committee heard testimony that our AMA efforts towards price transparency should include working with states and state medical associations to reduce insurance contract provisions and gag clauses. However, your Reference Committee also heard testimony that our AMA's efforts should not be limited to such actions and that existing policy provides more flexibility in advocating for price transparency. Therefore, your Reference Committee recommends affirming existing AMA policy D-155.987 in lieu of the first Resolve.

Similarly, your Reference Committee heard testimony that our AMA has strong policy to advance the second Resolve goals of our AMA working with states and state medical societies to ensure that health insurance contracts do not prohibit the application of discounts to uninsured or under-insured patients if such discounts are compliant with federal anti-kickback statutes. Therefore, your Reference Committee recommends reaffirmation of these policies in lieu of the second Resolve, Appropriate Hospital Charges H-155.958 and Physicians' Freedom to Establish Their Fees H-380.994.

Your Reference Committee also supports efforts to provide patients and physicians with prescription drug cost and coverage transparency when a physician is prescribing at the point of care. Your Reference Committee also heard testimony that a substantially similar resolution was referred for report back at Annual 2018 (219-A-17). Therefore, your Reference Committee recommends that third Resolve be referred for report back at Annual 2018.

D-155.987 Price Transparency

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

H-155.958 Appropriate Hospital Charges

Our AMA encourages hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients.

H-380.994, Physicians' Freedom to Establish Their Fees

Our AMA (1) affirms that it is a basic right and privilege of each physician to set fees for service that are reasonable and appropriate, while always remaining sensitive to the varying resources of patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner; (2) supports the concept that health insurance should be treated like any other insurance (i.e., a contract between a patient and a third party for indemnification for expense or loss incurred by virtue of obtaining medical or

other health care services); and (3) believes that the contract for care and payment is between the physician and patient.

(29) RESOLUTION 218 - HEALTH INFORMATION TECHNOLOGY PRINCIPLES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be referred.

HOD ACTION: Resolution 218 referred.

Resolution 218 asks that our American Medical Association adopt and promote the development of effective electronic health records in accordance with the following health information technology principles: 1. Whenever possible, physicians should have direct control over choice and management of the information technology used in their practices. 2. Information technology available to physicians must be safe (e.g., electronically secure, and in the case of distributed devices, physically so), effective and efficient. 3. Information technology available to physicians should support the physician's obligation to put the interests of patients first. 4. Information technology available to physicians should support the integrity and autonomy of physicians. 5. Information technology should support the patient's autonomy by providing access to that individual's data. 6. There should be no institutional or administrative barriers between physicians and their patients' health data. 7. Information technology should promote the elimination of health care disparities. 8. The cost of installing, maintaining and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules on an ongoing basis; payments should ensure sustainability of such systems in practice. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 218. Your Reference Committee agrees with testimony presented that our AMA has extensive policy on electronic health records (EHRs) to improve and advance health information technology. However, your Reference Committee heard testimony that clear and concise principles on information technology should be adopted in our AMA policy. Your Reference Committee also heard testimony that our AMA already has existing health information technology principles that were developed in 2013. These principles have been widely publicized and successfully used to accomplish many of our AMA's advocacy efforts. For example, our AMA was successful in adding information blocking provisions against vendors, requiring real-world testing of EHRs, prohibiting EHR gag clauses, increasing federal oversight of EHR functionality after certification, and requiring health information technology vendors to disclose fees among many accomplishments. However, your Reference Committee believes that further study is needed because technology has changed since the development of these principles. Through study, our AMA can properly incorporate Resolution 218 into new principles and to develop comprehensive EHR policy that further enhances physicians' ability to provide high quality patient care. Therefore, your Reference Committee recommends that Resolution 218 be referred.

(30) RESOLUTION 226 - PRESCRIPTION DRUG IMPORTATION FOR PERSONAL USE

RECOMMENDATION:

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

HOD ACTION: Resolution 226 referred.

Resolution 226 asks that our American Medical Association support legislation that would allow for the personal purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy, provided such drugs are for personal use and of a limited quantity. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 226 which calls upon our AMA to support personal importation from Canadian pharmacies. While there is unanimous agreement that more flexibility is needed to ensure patients have access to affordable prescription drugs, concern was expressed that the in-person personal

importation may eventually lead to the same risks as internet-based importation. Your Reference Committee also heard testimony that there should be sufficient resources to ensure that in-person importation is safe and traceable. Given these concerns, the lack of direct policy on in-person importation, and the complex nature of drug importation, your Reference Committee recommends that Resolution 226 be referred.

(31) RESOLUTION 234 - HEALTH INSURANCE COMPANY PURCHASE BY PHARMACY CHAINS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 234 be referred for decision.

HOD ACTION: Resolution 234 referred for decision.

Resolution 234 asks that the American Medical Association object to any purchase of a Health Insurance Plan by any Drug Store or Pharmacy Chain and that the AMA work with other stakeholders, including the AOA and specialty colleges, to advocate for protection against such a purchase.

Your Reference Committee heard mixed testimony on Resolution 234. Your Reference Committee heard that our AMA has vigorously opposed mergers of two health insurance companies. Your Reference Committee also heard testimony that this proposed merger has unknown impact on physicians and consumers, unknown effect on the health insurance industry when a pharmacy and health insurer merge, and unknown outcome as to whether the CVS/Aetna merger will even be completed. Your Reference Committee recognizes that antitrust is a highly complex and fact intensive issue. Opposing any merger or acquisition without extensive information gathering could hurt our AMA's credibility and authority in the antitrust space. Given these concerns and the timing of the potential merger, your Reference Committee recommends that this resolution be referred for decision.

(32) RESOLUTION 237 - IMPLEMENTATION OF SCORE ASSESSMENT FOR COST UNDER MACRA MIPS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 237 be referred for decision.

HOD ACTION: Resolution 237 referred for decision.

Resolution 237 asks that our American Medical Association work with CMS to ensure sound methodologies for risk adjustment for physicians with patient populations at risk for high resource use (Directive to Take Action); and be it further, that our AMA urgently lobby the Congress and the federal government to expedite development of an equitable, validated patient-specific risk adjustment mechanism and not include a cost score in the Merit Based Incentive Payment System (MIPS) until such time as it can be developed (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 237. Many who testified offered comments in support of the position that physicians should not receive a cost performance score in the Merit-Based Incentive Payment System (MIPS) until a validated patient-specific risk adjustment mechanism is developed, and that physicians should not be held responsible for cost measures until CMS can ensure they are accurate. Others testified in opposition of this resolution, noting that for the past several months our AMA has been discussing with state and specialty medical associations the need to amend the MACRA statute to extend the Centers for Medicare & Medicaid Services' (CMS) flexibility for weighing the cost performance category for an additional three years. Your Reference Committee also heard testimony that our AMA was joined by more than 60 national medical specialty societies and all state medical associations on a recent letter to key congressional committees of jurisdiction in support of allowing CMS additional flexibility on this and other MACRA provisions.

Your Reference Committee considered supplemental background information noting that the MACRA statute, which includes MIPS, provides that cost measures will account for 30 percent of the total MIPS score. The statute

also provides that for the first two years of MIPS implementation, CMS could weigh cost at not more than 10 percent for the first year (2017) and not more than 15 percent for the second year (2018) in recognition of the readiness of these measures. For 2017, CMS weighed cost at zero percent. For 2018, CMS originally proposed to again weigh cost at zero percent but ultimately chose to weigh the measures at 10 percent in the final rule. In the final rule, CMS noted several times that they plan to weigh cost at 30 percent in 2019 because of the statutory requirement. It is this requirement that our AMA and state and national medical associations have been seeking to amend. Your Reference Committee reviewed the letter mentioned above and notes that it included the following statement: “To be clear, we are not proposing to prevent CMS from implementing [cost] measurement or a higher performance threshold if they believe that moving forward with these elements is appropriate. Rather, we are proposing to continue the existing flexibility in the MACRA statute that CMS is currently using for an additional three years so that the agency may move forward as the necessary program elements are put in place.” Your Reference Committee also notes that the letter stated the medical community is not proposing to prevent CMS from implementing cost measurement if it believes that moving forward with these elements is appropriate.

Your Reference Committee heard testimony that the joint letter mentioned above, which included most of the sponsors of this resolution, was drafted and submitted prior to the release of the final MIPS rule and that circumstances have changed—primarily that the cost category was set at 10 percent in the final rule instead of zero percent as was proposed in the proposed rule. Your Reference Committee also heard testimony that this resolution would reverse course from our joint advocacy letter and seek to add another precondition on CMS’s ability to move forward that was not offered at the time of the original letter, and could raise questions as to the willingness of physician organizations to work in good faith with Congress to successfully implement the MIPS program. While your Reference Committee is very sympathetic to the position that physicians should not be subject to a MIPS cost performance score until a validated patient-specific risk adjustment mechanism is developed, your Reference Committee is recommending that this resolution be referred to the Board of Trustees for decision so that our AMA can further consult with the numerous medical societies that signed the joint letter and further discern the implications of this resolution relative to our current advocacy with Congress and CMS on this issue.

REPORT OF REFERENCE COMMITTEE F

(1) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON
COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations 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.

HOD ACTION: The Report of the House of Delegates Committee on the Compensation of the Officers adopted and the remainder of the Report filed.

The Report of the House of Delegates Committee on Compensation of the Officers recommends:

1. That there be no change to the current Definitions effective July 1, 2017 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External Representation and Telephonic Per Diem for External Representation.
2. That the Travel and Expense Standing Rules for AMA Officers, Rule I Section C9, Standard Benefits Package be changed to \$305,000 term life insurance.
3. Except as noted above, there be no other changes to the Officers compensation for the period beginning January 1, 2018.

Your Reference Committee noted that the report explained the increase in term life insurance coverage was due to the discontinuation of global medical emergency assistance coverage previously offered by the AMA Insurance Agency, Inc. Given the amount of travel Officers undertake on behalf of our AMA, this coverage was deemed essential. The Standard, the group life insurance provider for AMA employees, agreed to extend existing Travel Assistance coverage to AMA Officers provided the Officers enrolled in a \$5000 term life insurance policy, therefore increasing the term life insurance available to all Board Members to \$305,000 at a total cost of \$150.

Your Reference Committee also noted that results of a comprehensive compensation review undertaken in 2016 led to modest increases to the Governance Honorarium and Per Diems for Officer Compensation, excluding the Presidents and Chair, effective on July 1, 2017.

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.

(2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT
1 - SENIOR PHYSICIANS SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

**HOD ACTION: Council on Long Range Planning and Development Report 1
adopted and the remainder of the Report filed.**

Council on Long Range Planning and Development Report 1 recommends that our American Medical Association renew delineated section status for the Senior Physicians Section through 2022 with the next review no later than the 2022 Interim Meeting.

Your Reference Committee received testimony indicating that the Senior Physicians Section favors “fixed” section status like the Medical Student Section, the Resident and Fellow Section, and the Young Physicians Section thereby alleviating the need to reconfirm the Section’s qualifications for continued section status at least every five years. Your Reference Committee also heard testimony that the appropriate process for achieving a change in section status is for the Section to petition the Council on Long Range Planning and Development.

On behalf of our AMA House of Delegates, your Reference Committee wishes to extend its appreciation to the Council on Long Range Planning and Development and the Senior Physicians Section for their cooperative and collaborative efforts to present a thorough review of the Section. Your Reference Committee supports adoption of the report.

(3) **BOARD OF TRUSTEES REPORT 10 - HIGH COST TO AUTHORS FOR OPEN SOURCE PEER REVIEWED PUBLICATIONS**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 10 be amended by addition to read as follows:

The Board of Trustees recommends that Resolution 604-A-17 not be adopted and that this report be filed. AMA Publishing, however, plans to implement a process for waiving or reducing Open Access (OA) fees when authors are not supported by funders or cannot afford to pay OA fees.

The Board of Trustees will continue to monitor the Federal Trade Commission’s actions in relation to predatory publishers and will disseminate the information to our AMA members.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 10 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 10 adopted as amended and the remainder of the Report filed.

Board of Trustees Report 10 is presented in response to Resolution 604-A-17, which called upon our AMA to investigate the impact of the high costs of Open Access publication practices on the dissemination of research, especially by less well-funded and/or smaller entities, and to make recommendations to correct the imbalance of knowledge suppression that may occur because of financial limitations.

In this report, the Board of Trustees recommends that Resolution 604-A-17 not be adopted and that this report be filed. The Board of Trustees have further noted our AMA Publishing plans to implement a process for waiving or reducing Open Access fees if authors are not supported by funders or cannot afford to pay Open Access fees.

Your Reference Committee received limited testimony suggesting that Board of Trustees Report 10 be referred for further action. However, your Reference Committee believes that our AMA, which is mindful of conflict of interest considerations, has done all that it can at present to advocate for and lead the movement for widespread dissemination of medical knowledge and research, including making its own publishing processes more user friendly and affordable thereby serving as an example.

Your Reference Committee appreciates the fact that the Board report addressed predatory practices, which is beyond the scope of Resolution 604-A-17. Your Reference Committee believes that the proffered amendment to monitor and report on the Federal Trade Commission's actions in response to predatory publishers will keep our AMA members abreast of abusive publishing practices.

(4) RESOLUTION 601 - PHYSICIAN BURNOUT AND WELLNESS
CHALLENGES
RESOLUTION 604 - PHYSICIAN AND PHYSICIAN ASSISTANT SAFETY
NET
RESOLUTION 605 – IDENTIFICATION AND REDUCTION OF
PHYSICIAN DEMORALIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 601, 604, and 605 be referred with report back at the 2018 Annual Meeting.

HOD ACTION: Resolutions 601, 604, and 605 referred with report back at the 2018 Annual Meeting.

Resolution 601 calls upon our AMA to advocate for health care organizations and state and county medical societies, to develop a wellness plan to prevent and combat physician burnout and improve physician wellness.

Resolution 604 calls upon our AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians and funded by such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

Resolution 605 calls upon our AMA to recognize physician demoralization as a consequence of externally imposed occupational stresses, including but not limited to EHR-related and administrative burdens imposed by health systems or by regulatory agencies, as a problem among medical staffs. Resolution 605 also calls upon our AMA to advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization.

Resolution 605 further calls upon our AMA 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 wellness.

Your Reference Committee heard extensive and impassioned testimony and online comments with suggested amendments on Resolutions 601, 604 and 605. Your Reference Committee recognizes that one of our AMA's three focus areas is the professional satisfaction of physicians, and within that area, the spectrum of physician wellness remains a vitally important area of involvement and effort for our AMA. It is apparent that these issues affect every physician and medical student, and many and varied strategies and tactics have been employed with varying degrees of success to combat work-related stresses. Testimony coalesced around some common themes, as follows:

- The terminology used to describe what is commonly referred to as burnout concerned many who testified, because burnout may be interpreted to be a pejorative and stigmatizing term. Although AMA policy D-310.968, "Physician and Medical Student Burnout" describes burnout, a term that many favored, there was strong testimony to use other nomenclature, including demoralization and a spectrum of the condition, but there was no clear consensus expressed favoring any single term.
- The root causes of physician and medical student burnout urgently need to be identified and addressed.
- Physician and medical student wellness programs and related strategies to ameliorate burnout should be driven by the medical staff and should focus on empowering physicians, not victimizing them.

- Physicians and medical students may be reluctant to reach out for help or contact suicide hotlines with overwhelming work-related stress because they fear breaches of confidentiality, retaliation by an employer, loss of privileges and licensure, and other forms of stigmatization. However, successful physician suicide hotlines and other Physician Health programs have been developed and implemented.
- Our AMA should consider convening a comprehensive task force to research best practices, analyze differences between various regional and specialty society physician wellness programs, standardize terminology, review our existing AMA policies and programs, and design and administer a clearinghouse of information on programs and strategies that optimize physician and medical student wellness.

Your Reference Committee received testimony from our AMA Board of Trustees expressing its support for referral of these three resolutions as a group for an aggressive and comprehensive response in an expedited manner. Therefore, your Reference Committee recommends referral of these three resolutions with a report back at the 2018 Annual Meeting.

REPORT OF REFERENCE COMMITTEE J

(1) COUNCIL ON MEDICAL SERVICE REPORT 1 - AFFORDABLE CARE ACT SECTION 1332 WAIVERS

RECOMMENDATION:

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

**HOD ACTION: The recommendations of Council on Medical Service Report 1
adopted and the remainder of the report filed.**

Council on Medical Service Report 1 recommends that our AMA support the criteria outlined in Section 1332 of the Affordable Care Act for the approval of State Innovation Waivers: a. The waiver proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver; b. The waiver proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; c. The waiver proposal will provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and d. The waiver proposal will not increase the federal deficit. The report also recommends that our AMA support the deficit neutrality requirement of Section 1332 waivers being enforced over the period of the waiver and in total over the ten-year budget plan submitted by a state, not in each individual year of the waiver; and support legislation to allow other federal savings projected to be achieved as a result of a Section 1332 waiver, including any reductions in the cost of the tax exclusion for employer-sponsored coverage, to be included in the amount of federal pass-through funding provided to a state to subsidize state innovations.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 1. A member of the Council on Medical Service introduced the report, noting that states submitting applications for Section 1332 waivers need flexibility in two arenas – first, with respect to meeting deficit neutrality requirements in the longer term versus annually, and second, regarding the federal funding that is passed through to them to implement their waivers. Your Reference Committee believes that the recommendations of the report constitute important steps to improve the ability of states to fund Section 1332 waivers that allow for state innovation in providing health insurance coverage, and recommends that the recommendations of Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 3 - NON-PHYSICIAN SCREENING TESTS

RECOMMENDATION:

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

**HOD ACTION: The recommendations of Council on Medical Service Report 3
adopted as amended and the remainder of the report filed.****3. That it be the policy of our AMA that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles:**

- a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines;**
- b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed;**

- c. Must disclose the qualifications of any persons in contact with the patient and of any persons interpreting the results of any screening test;
- d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure;
- e. Should send results of any screening only to the individual patient and to the primary care physician or usual source of medical care, upon patient request; and
- f. Should require a consultation with the patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result; and
- g. If the test results are of a critical level or value, the patient should be contacted immediately and notified of the need for urgent or emergent medical evaluation. (New HOD Policy)

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-425.994 and H-425.997; and that it be the policy of our AMA that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles: a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines; b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed; c. Must disclose the qualifications of any persons in contact with the patient and of any persons interpreting the results of any screening test; d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure; e. Should send results of any screening only to the individual patient; and f. Should require a consultation with the patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result. The report also recommends that our AMA support that physicians not be held liable for delayed or missed diagnoses indicated on wellness program vendor non-physician ordered screenings and to rescind Policy H-425.996.

There was unanimous supportive testimony on Council on Medical Service Report 3. A member of the Council on Medical Service introduced the report. Testimony thanked the Council on Medical Service for its comprehensive report recognizing the importance of ensuring continuity of care in the arena of non-physician screenings. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - HEALTH INSURANCE AFFORDABILITY: ESSENTIAL HEALTH BENEFITS AND SUBSIDIZING THE COVERAGE OF HIGH-RISK PATIENTS

RECOMMENDATION:

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

HOD ACTION: The recommendations of Council on Medical Service Report 4 adopted and the remainder of the report filed.

Council on Medical Service Report 4 recommends that our AMA oppose the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; oppose waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses; prefer reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients; and rescind Policy H-165.995.

Your Reference Committee heard mixed but predominantly supportive testimony on Council on Medical Service Report 4. In introducing the report, a member of the Council on Medical Service stressed that protecting current EHB categories is critical not only to ensure that patients have meaningful health insurance coverage, but that patients also are protected against annual and lifetime limits, and out-of-pocket expenses. In response to testimony

highlighting the need for state variation in EHBs, a member of the Council on Medical Service stressed that the current approach to EHBs is not a one-size-fits all-approach. Currently, states can choose one of four benchmark plan options for EHBs: 1) The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; 2) Any of the largest three state employee health benefit plans by enrollment; 3) Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; and 4) The largest insured commercial non-Medicaid health maintenance organization operating in the state.

A member of the Council on Medical Service also outlined that data has shown that reinsurance programs, including the ACA's temporary reinsurance program as well as state reinsurance programs, have been effective in reducing premiums while ensuring that patients with pre-existing conditions enjoy the same protections as healthy patients. Concerns were raised with the third and fourth recommendations of the report. However, and importantly, a member of the Council on Medical Service underscored that the AMA will still be able to support high-risk pools, as Policy H-165.842 remains in place. Policy H-165.842 supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market regulation; and supports state-based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies.

A member of the Council on Legislation noted that this report is incredibly timely, as some legislative proposals introduced and/or considered this year included provisions to allow for EHB changes, or for people with pre-existing conditions to be placed in high-risk pools – approaches that could have caused a significant number of Americans to lose access to affordable health insurance coverage. In addition, testimony underscored that the recommendations of the report are very much consistent with AMA's advocacy efforts this year to ensure individuals have access to quality, affordable health insurance coverage and to the medical care they need, and maintain protections for people with pre-existing conditions. Your Reference Committee notes that the report is also consistent with the AMA vision for health system reform released at the 2016 Interim Meeting. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 5 - REAFFIRMATION OF AMA POLICY OPPOSING CAPS ON FEDERAL MEDICAID FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: The recommendations of Council on Medical Service Report 5 adopted and the remainder of the report filed.

Council on Medical Service Report 5 recommends that our AMA reaffirm Policy H-290.963.

Your Reference Committee heard generally supportive testimony on Council on Medical Service Report 5. Your Reference Committee believes that this report sends a concise and consistent message in opposition to capping federal Medicaid funds. As such, your Reference Committee recommends that the recommendation of Council on Medical Service Report 5 be adopted and that the remainder of the report be filed.

(5) RESOLUTION 802 - OPPOSITION TO MEDICAID WORK REQUIREMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 802 be adopted.

HOD ACTION: Resolution 802 adopted.

Resolution 802 asks that our AMA oppose work requirements as a criterion for Medicaid eligibility.

Your Reference Committee heard generally supportive testimony on Resolution 802. Many speakers testified that Medicaid work requirements do not reflect the employment status of the adult Medicaid population. Data shared by many speakers, including a member of the Council on Medical Service, indicate that nearly 8 in 10 Medicaid adults are in working families, with nearly 60 percent working themselves. Of those nonelderly adults who are not working, 35 percent cite an illness or disability that prevents them from work, 28 percent cite they are taking care of their home or family, 18 percent are in school, 8 percent are looking for work and 8 percent are retired.

Considering that most Medicaid beneficiaries who can work already do – only three percent of adult enrollees outside of the categories listed above are not working or actively looking for work – testimony stressed that Medicaid work requirements would yield little or no improvement in employment among the population. At the same time, speakers noted that Medicaid work requirements would increase administrative burdens and costs for states, while imposing additional documentation burdens on a vulnerable population. Speakers stressed that imposing Medicaid work requirements could cause some individuals currently covered by Medicaid to become uninsured, counter to AMA policy and advocacy efforts this year protecting Medicaid and preserving the program as a safety net. Testimony also highlighted that this resolution is incredibly timely, as seven states have submitted waivers to allow for Medicaid work requirements. Your Reference Committee agrees with testimony provided, and recommends that Resolution 802 be adopted.

(6) RESOLUTION 803 - AIR AMBULANCE REGULATIONS AND REIMBURSEMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 803 be adopted.

HOD ACTION: Resolution 803 adopted.

Resolution 803 asks that our AMA and appropriate stakeholders study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement.

Testimony on Resolution 803 was supportive. An amendment was offered to request that the AMA advocate for repeal of the Airline Deregulation Act, however your reference committee finds this amendment highly prescriptive and premature without further study. Accordingly, your Reference Committee recommends that Resolution 803 be adopted.

(7) RESOLUTION 811 - UPDATE OBRA NURSING FACILITY PREADMISSION SCREENING REQUIREMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 811 be adopted.

HOD ACTION Resolution 811 adopted.

Resolution 811 asks that our AMA work with the US Department of Health and Human Services and Congress to amend applicable statutes and regulations to revise the Preadmission Screening and Resident Review requirement for nursing facility placement to provide more consistent enactment among states and to allow more reasonable and cost-effective approaches to this mandatory screening process.

There was supportive testimony on Resolution 811. Testimony noted that this resolution is consistent with AMA policy on the three-day stay rule. Your Reference Committee agrees and recommends that Resolution 811 be adopted.

(8) RESOLUTION 818 - ON-CALL AND EMERGENCY SERVICES PAY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 818 be adopted.

HOD ACTION: Resolution 818 adopted.

Resolution 818 asks that our AMA amend Policy H-130.948 to include the statement that "physicians should be provided adequate compensation for being available and providing on-call and emergency services;" and develop and make available policy guidance for physicians to negotiate with hospital medical staffs to support physician compensation for on call and emergency services.

Your Reference Committee heard generally supportive of testimony on Resolution 818. Speakers stressed the need for physicians to be adequately compensated for being available and providing on-call and emergency services. There was an amendment offered to specify that adequate compensation be based on fair market value, which your Reference Committee believes may be too prescriptive. Also, the use of "adequate compensation" is consistent with the terminology used in Policy H-130.948. Your Reference Committee believes that Resolution 818 should be adopted.

(9) RESOLUTION 819 - CONSULTATION CODES AND PRIVATE PAYERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 819 be adopted.

HOD ACTION: Resolution 819 adopted.

Resolution 819 asks that our AMA proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change; and a reason given by an insurance company for the policy change to discontinue payment of consultation codes includes purported coding errors or abuses, request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

There was supportive testimony on Resolution 819. Testimony stated that discontinuing payment of consultation codes only serves to create a barrier to care and prevents patients from receiving specialty care. Additionally, testimony stated that such policies fail to recognize the expertise and additional collaboration that is reflected in the use of consultation codes. Testimony noted that physicians must be allowed enough time to be educated on how to comply with new coding guidelines in order to avoid payment disruptions. An amendment was offered to include mention of the Centers for Medicare and Medicaid Services (CMS) in addition to private payers; however, your Reference Committee believes Resolution 819 is intended to address commercial insurers who have recently discontinued payment for consultation codes or insurers who are presently proposing the elimination of consultation codes, of which CMS is neither after eliminating consultation codes in 2010. Additionally, your Reference Committee notes that the AMA already supports legislation to overturn CMS action to eliminate reimbursement for consultation codes (Policy D-70.953) and does not see the need to include CMS in Resolution 819. Accordingly, your Reference Committee recommends that Resolution 819 be adopted.

(10) RESOLUTION 820 - ELIMINATION OF THE LABORATORY 14-DAY RULE UNDER MEDICARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 820 be adopted.

HOD ACTION: Resolution 820 adopted.

Resolution 820 asks that our AMA actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments.

Your Reference Committee heard generally supportive testimony on Resolution 820. Your Reference Committee believes that Resolution 820, without suggested changes, is focused and consistent with AMA advocacy on this issue, and recommends its adoption.

(11) RESOLUTION 825 - SUPPORT FOR VA HEALTH SERVICES FOR WOMEN VETERANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 825 be adopted.

HOD ACTION: Resolution 825 adopted.

Resolution 825 asks that our AMA recognize the disparity in access to care for women veterans; and encourage research to address this population's specific needs to improve patient outcomes.

Your Reference Committee heard highly supportive testimony on Resolution 825. Your Reference Committee believes that Resolution 825 is consistent with AMA policy in support of providing quality care to veterans, as well as ensuring that veterans have timely access to the medical care they need within close proximity to their residence. As such, your Reference Committee recommends that Resolution 825 be adopted.

(12) RESOLUTION 827 - HOSPITAL ACCREDITATION PROGRAMS AND MEDICAL STAFFS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 827 be adopted.

HOD ACTION: Resolution 827 adopted.

Resolution 827 asks that our AMA engage accrediting organizations to ensure that their hospital accreditation standards acknowledge the medical staff's essential role in the provision of high quality care, and otherwise appropriately position the medical staff to fulfill its responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.

Your Reference Committee heard limited yet supportive testimony on Resolution 827. Your Reference Committee believes Resolution 827 is consistent with existing AMA policy addressing the role of the medical staff in providing quality care, and recommends its adoption.

(13) COUNCIL ON MEDICAL SERVICE REPORT 2 - HOSPITAL SURVEYS
AND HEALTH CARE DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our American Medical Association oppose hospital quality program assessments that have the effect of financially penalizing physicians, including those practicing in safety net hospitals. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: The recommendations of Council on Medical Service Report 2 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 2 recommends that our AMA reaffirm Policies H-450.966, D-385.958, H-450.982 and H-295.897; support that the goal of hospital quality program assessments should be to identify areas to improve patient outcomes and quality of patient care; recognize the importance of cultural competency to patient experience and treatment plan adherence and encourage the implementation of cultural competency practices across health care settings; support that hospital quality program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities; continue to advocate for better risk models that account for social risk factors in hospital quality program assessments; and continue to work with CMS and other stakeholders, including representatives of America's Essential Hospitals, to address issues related to hospital quality program assessments.

Testimony on Council on Medical Service Report 2 was unanimously supportive. A member of the Council on Medical Service introduced the report. Testimony suggested that not only should hospital quality program assessments not financially penalize safety net hospitals, but they should not financially penalize physicians. The Council on Medical Service accepted this friendly amendment. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

(14) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - PAYMENT AND COVERAGE FOR GENETIC/GENOMIC PRECISION MEDICINE

RECOMMENDATION A:

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

~~8. That our AMA modify Policy D-460.971 by addition and deletion to read as follows:~~

~~Our AMA: (1) encourages payers, regulators and providers to make clinical variant data and their interpretation publicly available through a system that assures patient and provider privacy protection; and (2) encourages laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results, into the public domain which would allow~~

~~appropriate interpretation and surveillance for these variations that can impact the public's health; and (3) encourages laboratories to establish a process by which patients and their physicians could be notified when interpretation and clinical significance changes for previously reported variants. (Modify Current HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 11 of Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition to read as follows:

11. That our AMA work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical impact. (New HOD Policy)

RECOMMENDATION C:

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.

HOD ACTION: The recommendations of the Joint Report of the Council on Medical Service and the Council on Science and Public Health adopted as amended and the remainder of the report filed.

The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our reaffirm Policies H-460.968, H-460.908, D-480.987, H-185.939, H-329.949, H-65.969 and H-460.902; modify Policy D-460.971 by addition and deletion to encourage laboratories to establish a process by which patients and their physicians could be notified when interpretation and clinical significance changes for previously reported variants; encourage public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that: a. Promote transparency and clarity, b. Involve multidisciplinary stakeholders, including genetic/genomic medicine experts and relevant national medical specialty societies, c. Describe the evidence being considered and methods for updating the evidence, d. Provide opportunities for comment and review as well as meaningful reconsiderations and e. Incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival; encourage coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through randomized controlled trials, and work with test developers and appropriate clinical experts to establish clear thresholds for acceptable evidence for coverage; work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics; encourage national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services; and support continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was supportive. An amendment was offered to add a phrase to Recommendation 11 to encourage the development of payment strategies for genetic/genomic tests and therapeutics that have clinical impact. The Council on Medical Service testified that it found the amendment friendly, and your Reference Committee accepts the amendment. Additional testimony raised concerns that the proposed modification of policy in Recommendation 8 may open up physicians to liability and lead to a slippery slope. Further, testimony noted that the proposed modification posed a daunting task to physicians, particularly with constantly changing data and the lack of registries to revisit the necessary information at this time. Therefore, your Reference Committee suggests striking Recommendation 8 and highlighting that, in future reports on precision medicine, the issue in Recommendation 8 should be addressed.

Accordingly, 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.

(15) RESOLUTION 801 - CHRONIC CARE MANAGEMENT PAYMENT FOR PATIENTS ALSO ON HOME HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 801 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for the authorization of Chronic Care Management (CCM) reimbursement for all physicians, including those practicing in Rural Health Clinics, and Federally Qualified Health Centers, and all other physician clinics providing CCM for patients enrolled in a home health episode, to the Centers for Medicare and Medicaid Services and to Congress if federal law must be amended. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 801 be adopted as amended.

HOD ACTION: Resolution 801 adopted as amended.

Resolution 801 asks that our AMA advocate for the authorization of Chronic Care Management (CCM) reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and all other physician clinics providing CCM for patients enrolled in a home health episode, to the Centers for Medicare and Medicaid Services and to Congress if federal law must be amended.

Testimony on Resolution 801 was supportive. An amendment was offered to be inclusive of all physicians, and your Reference Committee accepts this amendment. Testimony further suggested deletion of the reference to specific advocacy efforts, and your Reference Committee accepts this amendment noting that it allows the AMA to advocate through any avenues as appropriate. Accordingly, your Reference Committee recommends that Resolution 801 be adopted as amended.

(16) RESOLUTION 806 - MANDATE TRANSPARENCY BY PHARMACY BENEFIT MANAGERS

RESOLUTION 810 - PHARMACY BENEFIT MANAGERS AND PRESCRIPTION DRUG AFFORDABILITY

RESOLUTION 823 - UNCONSCIONABLE GENERIC DRUG PRICING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 806, 810 and 823.

HOD ACTION: The following resolution adopted in lieu of Resolutions 806, 810 and 823.

PRESCRIPTION DRUG PRICE AND COST TRANSPARENCY

RESOLVED, That our AMA reaffirm Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers (PBMs) and health insurance companies; and

supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug by 10% or more each year or per course of treatment and provide justification for the price increase, and legislation that authorizes the Attorney General and/or the Federal Trade Commission (FTC) to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-125.986, which encourages the FTC and the Food and Drug Administration 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; and 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 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-125.979 containing provisions to improve private health insurance formulary transparency (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA oppose provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price (New HOD Policy); and be it further

RESOLVED, That our AMA continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation on the development and management of pharmacy benefits (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase (New HOD Policy); and be it further

RESOLVED, That our AMA continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign (Directive to Take Action).

Resolution 806 asks that our AMA ask Congress and other appropriate entities to require that there be transparency of drug pricing by pharmacy benefit managers (PBM) to help prevent PBM price manipulation of patient prescription costs; and advocate for policy that retail pharmacies and health plans be required to disclose to patients the lowest possible cost of any prescription medication--specifically, any price differential between the price of a drug when using an insurance benefit vs the price of the drug without using that benefit.

Resolution 810 asks that our AMA expand the Truth in Rx advocacy campaign to include and explicitly address through educational outreach the effects of pharmacy benefit manager (PBM) practices on drug prices and access to

affordable treatment; engage in efforts to educate federal lawmakers about the role of PBM practices in drug pricing and urge Congressional action to increase transparency of PBM practices; work at the federal and state level to increase transparency for PBMs by: eliminating increases in patient cost-sharing obligations for prescription drugs if such drugs are chosen for profit to the PBM, restricting PBM use of non-medical switching and other utilization management techniques related to PBM formulary development that disrupt the patient treatment plan, and further regulating PBM practices in order to ensure patients have access to effective and affordable medication therapies; and develop model guidelines for effective and meaningful transparency in the rebate system, to include PBM and health plan disclosure to physicians of the contracted cost of medications including discounts and rebates from manufacturers paid back to health plans and PBMs, and urge PBMs to take active steps to implement those guidelines.

Resolution 823 asks that our advocate for national legislation that will prohibit price gouging on off-patent medications where there are fewer than three manufacturers and where there have been no external factors to justify the price increase; and report back at the 2018 Annual Meeting on the results of the AMA Truth in Rx Campaign designed to bring attention to the rising prices of prescription drugs and the status of any proposed legislation on drug pricing transparency, price gouging, and expedited review of generic drug applications as called for in AMA Policy H-110.987.

There was highly supportive testimony on Resolutions 806, 810 and 823. Members of the Council on Medical Service and Council on Legislation supported crafting a substitute resolution in lieu of Resolutions 806, 810 and 823, to develop a new, concise message on prescription drug price transparency, while rectifying any overlap between the resolutions. A member of the Council on Legislation noted that the AMA has model bills addressing this issue, and is actively engaged on this issue through its efforts with the National Association of Insurance Commissioners.

Considering the overlap between the recommendations and intent of Resolutions 806, 810 and 823, your Reference Committee has crafted a substitute that comprehensively addresses the issue of prescription drug price and cost transparency incorporating the recommendations of the resolutions, including those that are already AMA policy. Resolutions 810 and 823 included recommendations addressing AMA's TruthinRx grassroots campaign, which aims to expand drug pricing transparency among pharmaceutical manufacturers, pharmaceutical benefit managers and health plans. In addition, the TruthinRx website explicitly includes content addressing practices of PBMs highlighted in testimony. Resolution 823 called for a report back on the results of the TruthinRx campaign, which your Reference Committee believes is appropriate. With the content of the TruthinRx website very recently being updated, your Reference Committee believes a report back to the House of Delegates at the 2018 Interim Meeting would be appropriate to allow for sufficient time to gather metrics and data to truly measure the campaign's progress and impact.

H-110.987 Pharmaceutical Costs

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before

increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17)

H-125.986 Pharmaceutical Benefits Management Companies

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; and (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. (BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533 A-03; Reaffirmation I-08; Reaffirmation A-10)

H-125.979 Private Health Insurance Formulary Transparency

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. 2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term. 3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term. 4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours. 5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription. 6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans. (Sub. Res. 724, A-14; Appended: Res. 701, A-16)

(17) RESOLUTION 808 - OPPOSITION TO REDUCED PAYMENT FOR THE 25 MODIFIER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 808:

HOD ACTION: The following resolution adopted as amended in lieu of Resolution 808:

RESOLVED, That our American Medical Association aggressively and immediately advocate through any legal means possible, including direct payer

negotiations, regulations, legislation, or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate. (Directive to Take Action)

Resolution 808 asks that our AMA amend Policy D-70.971 by addition and deletion, including to state that our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers and, in the case where a procedure is appropriately modified by a modifier – 25, require that both the procedure and evaluation and management are paid at 100% of the non-reduced, allowable payment rate.

There was supportive testimony on Resolution 808. A delegate serving on the AMA/Specialty Society Resource-Based Relative Value Scale (RVS) Update Committee (RUC) offered alternative language. The delegate testified that the RUC Research Subcommittee is looking into E&M services to determine if they are reimbursed appropriately. A member of the Council on Medical Service offered support for the alternate language and testified that the proposed change to the Model Managed Care Contract in the resolution was to a degree of specificity that is unprecedented. The member testified that the Council on Medical Service believes the proposed alternate language proactively addresses this issue of the modifier 25. Your Reference Committee agrees and accepts the alternative language with a note that the AMA should aggressively advocate on this issue. An amendment was offered to target advocacy efforts specifically to Anthem; however, your Reference Committee found this mention overly prescriptive and notes that, as written, the alternative language encompasses all payers, including Anthem. Further testimony offered an amendment dictating how the AMA should go about rectifying this issue with insurers, and your Reference Committee rejects this amendment and believes the alternate language allows flexibility in the requested advocacy efforts. An additional amendment called for the AMA to develop educational materials disclosing the negative consequences of the insurer policies at issue for patients and insurance purchasers to corporate health benefit managers. Your Reference Committee does not find the need to launch an educational campaign to insurers who are not currently implementing such policies. Further testimony also called for immediate action. Your Reference Committee recognizes the immediate need to advocate on the insurer policies at issue.

Your Reference Committee highlights that the AMA is actively involved in ongoing discussions with insurers over potentially inappropriate insurer policy changes and is involved in legislative campaigns on such issues. Therefore, the AMA can incorporate this issue into such discussions and campaigns. For the reasons stated above, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 808.

(18) RESOLUTION 814 - APPROPRIATE REIMBURSEMENT FOR
EVALUATION AND MANAGEMENT SERVICES FOR PATIENTS WITH
SEVERE MOBILITY-RELATED IMPAIRMENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 814 be amended by addition of a fourth Resolve to read as follows:

RESOLVED, That our AMA support additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 814 be adopted as amended.

HOD ACTION: Resolution 814 adopted as amended.

Resolution 814 asks that our AMA support additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related

impairments; support that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; and support that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care.

There was supportive testimony on Resolution 814. Your Reference Committee notes that the AMA's comments on the 2017 Physician Fee Schedule Proposed Rule opposed CMS' plan to eliminate the 2017 physician payment increase Congress provided in MACRA in order to fund an add-on payment for services provided to patients with mobility-related disabilities. The comment letter stated that there is no justification for funding these services with an overall cut in physician payment rates. An amendment was offered to request that additional payment for providing care to patients with mobility-related disabilities not be done through a budget neutral adjustment to the fee schedule. Your Reference Committee accepts this amendment and recommends that Resolution 814 be adopted as amended.

(19) RESOLUTION 824 - PAYMENT FOR DEMENTIA TREATMENT IN HOSPITALS AND OTHER PSYCHIATRIC FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 824 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with relevant specialty societies urgently convene a task force with all interested stakeholders to promote appropriate payment by the Centers for Medicare and Medicaid Services and other third-party payers for treatment for all types of dementias when patients are treated in an Joint Commission accredited facility, whether a free-standing or part of a general medical facility, even when dementia is the primary diagnosis for admission. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 824 be adopted as amended.

HOD ACTION: Resolution 824 adopted as amended.

Resolution 824 asks that our AMA urgently convene a task force with all interested stakeholders to promote appropriate payment by the Centers for Medicare and Medicaid Services and other third-party payers for treatment for all types of dementias when patients are treated in a Joint Commission accredited facility, whether a free-standing or part of a general medical facility, even when dementia is the primary diagnosis for admission.

Your Reference Committee received supportive testimony on Resolution 824. One speaker suggested that this resolution may be overly prescriptive with mention of a task force and limiting this to Joint Commission accredited facilities. Your Reference Committee agrees with these amendments and specifically believes that the formation of a task force, which carries a significant fiscal note, is not a prudent use of limited AMA resources. Accordingly, your Reference Committee recommends that Resolution 824 be adopted as amended.

(20) RESOLUTION 813 - SUSTAIN PATIENT-CENTERED MEDICAL HOME PRACTICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 813 be referred.

HOD ACTION: Resolution 813 referred.

Resolution 813 asks that our AMA make an amendment to Policy H-160.918; and encourage the Centers for Medicare and Medicaid Services to subsidize the cost of sustaining Patient-Centered Medical Home designated practices for practicing physicians.

Testimony on Resolution 813 was supportive. An amendment was offered to include recognized Patient-Centered Specialty Practices in the second resolve and to increase payment rates for physician operating Patient-Centered Medical Homes (PCMHs). A member of the Council on Medical Service thanked the sponsor of Resolution 813. The member noted that the PCMH has evolved greatly within the last decade yet current policy on the PCMH predates both the Medicare Access and CHIP Reauthorization Act and the Affordable Care Act. Therefore, the member of the Council on Medical Service welcomed referral to revise current policy on PCMHs keeping in mind the issues raised by the sponsors of Resolution 813 and those offering amendments. The member further testified that, if referred, the Council on Medical Service believes it can come back to the House of Delegates with a more up-to-date and comprehensive policy on PCMHs. Your Reference Committee agrees, and recommends that Resolution 813 be referred.

(21) RESOLUTION 816 - SOCIAL DETERMINANTS OF HEALTH IN PAYMENT MODELS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 816 be referred.

HOD ACTION: Resolution 816 referred.

Resolution 816 asks that our AMA support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems.

There was supportive testimony on Resolution 816. Numerous speakers testified for referral of Resolution 816 stating that the policy proposal was vague and that it is unclear who is doing this screening and how much time the screening would take. Additional testimony noted that Resolution 711 from the 2017 Annual Meeting on screening tools for social determinants of health was referred for study and notes that referral of Resolution 816 may be incorporated into the current study. Your Reference Committee agrees and therefore recommends referral of Resolution 816.

(22) RESOLUTION 817 - ADDRESSING THE SITE OF SERVICE DIFFERENTIAL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 817 be referred.

HOD ACTION: Resolution 817 referred with report back at the 2018 Annual Meeting.

Resolution 817 asks that our AMA study the Site of Service Differential with a report back no later than the 2018 Interim Meeting, including: a) The rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) The increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) The expense of maintaining hospital based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) The methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges. The resolution also asks that our AMA advocate for a combined Health Care Payment System for patients who receive care that is paid for by the Centers for Medicare and Medicaid Services (CMS), that: a) Follows the recommendation of MedPAC to pay "Site-Neutral" reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient

Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS); b) Pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) Provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

There was generally supportive testimony on Resolution 817. A number of speakers stated that adoption of the second resolve is premature at this time without further study.

A member of the Council on Legislation (COL) called for referral. The COL member testified that adopting a payment policy to address differentials in payment between hospital-owned facilities and independently owned physician practices is highly complex. Further, the member of COL stated that, due to the focus on cost reduction in the current environment, it is unrealistic to imagine that physician payments would be raised to match any higher facility payments. Therefore, the member noted that COL has concerns that if the AMA advocated for a single payment system, the Centers for Medicare and Medicaid Services would pick the lower of the Ambulatory Surgical Center (ASC), Hospital Outpatient Department (HOPD), or Physician Fee Schedule (PFS) amount and pay all providers at that rate or it might simply reduce payments on the physician side as it did in 2014 when it proposed to cut physician pay to the same level as HOPD or ASC payments where physician payments were higher. The member testified that this action would not provide any relief for physicians in independent practices, while potentially reducing resources available for items such as equipment and salaries at hospital-owned facilities.

Furthermore, the member testified that there is a possibility that the Centers for Medicare and Medicaid Services, in order to reduce workload, may impose the payment system in use for HOPDs and ASCs on physician payments, which would result in a number of services being grouped together and paid at the same rate based on data from hospital cost reports, not physician costs, and that imposing a combined, group payment methodology on physicians might harm efforts by physician and specialty societies to develop alternative payment models. Taken together, the member testified that COL believes it would be premature to adopt this resolution without further analysis.

A member of the Council on Medical Service echoed the call for referral stating that this is a highly complex, multi-faceted resolution touching on not only site of service but also EHRs and uncompensated care. Therefore, the member stated that it is premature to adopt the second resolve without appropriate study and believes the entirety of Resolution 817 should be referred. Your Reference Committee agrees, and recommends that Resolution 817 be referred.

(23) RESOLUTION 812 - MEDICARE COVERAGE OF SERVICES PROVIDED BY PROCTORED MEDICAL STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 812 not be adopted.

HOD ACTION: Resolution 812 referred with report back at the 2018 Annual Meeting.

Resolution 812 asks that our AMA amend Policy H-390.999 to state that when a physician assumes responsibility for the services rendered to a patient by a medical student, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision; and work with the Centers for Medicare and Medicaid Services to require coverage of medical services performed by medical students while under the physician's personal observation, direction, and supervision.

There was testimony calling for referral of Resolution 812. However, your Reference Committee does not find the need to refer this issue due to the Centers for Medicare and Medicaid Services' (CMS) policy on payment for services rendered by students and has concerns that physicians are already paid for their services and believes allowing for such a policy may amount to getting paid twice. Additionally, your Reference Committee has liability concerns about allowing physicians to bill for services performed by medical students and believes that such a policy would undermine the student's role as learner. Moreover, there was testimony from the Council on Medical Education calling for Resolution 812 to not be adopted. The testimony noted that the teaching physician billing

guidelines from CMS state that any contribution and participation of a student to the performance of a billable service must be performed in the presence of a teaching physician or resident for a service that meets teaching physician's billing requirements. In addition, testimony stated that CMS only reimburses for services provided by licensed physicians, which medical students are not. Therefore, your Reference Committee recommends that Resolution 812 not be adopted.

(24) RESOLUTION 805 - A DUAL SYSTEM FOR UNIVERSAL HEALTH CARE IN THE UNITED STATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-165.838 and H-165.920 be reaffirmed in lieu of Resolution 805.

HOD ACTION: Policies H-165.838 and H-165.920 reaffirmed in lieu of Resolution 805.

Resolution 805 asks that our AMA vigorously advocate for compromise health care reform legislation which restructures all existing government health care programs into a single universal government system which provides health care to all United States citizens and legal residents at a level which is sustainable and affordable; simultaneously, with equal vigor, advocate for a far reaching deregulation of privately purchased health care, while maintaining the emphasis on improving quality and safety; resist all legislation which attempts to coerce or infringe upon the freedom of the people of the United States to choose the terms of their health care; and advocate for both public and private health care reforms as an inseparable package.

Your Reference Committee heard mixed testimony on Resolution 805. Many speakers raised concerns with establishing policy in support of a single payer system, as well as complete deregulation of private insurance. There were calls to reaffirm policy in lieu of the resolution. A member of the Council on Medical Service noted that the Council is presenting two additional reports at the upcoming Annual Meeting targeted at improving health insurance affordability and competition, which will also include studying the feasibility of a public option. Your Reference Committee believes that the policy of our AMA related to health reform needs to continue to emphasize pluralism, freedom of choice, freedom of practice and universal access to patients. As such, your Reference Committee believes that Policies H-165.838 and H-165.920 be reaffirmed in lieu of Resolution 805.

H-165.838, Health System Reform Legislation

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care f. Implementation of medical liability reforms to reduce the cost of defensive medicine g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. 5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of

Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 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. 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17)

H-165.920, Individual Health Insurance

Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health

insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax; (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14)

(25) RESOLUTION 809 - EXPANSION OF NETWORK ADEQUACY POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Policies H-285.952 and H-285.991 be reaffirmed in lieu of Resolution 809.

HOD ACTION: Resolution 809 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-285.908 by addition to read as follows:

Network Adequacy H-285.908

12. Our AMA supports requiring that health insurers that terminate in-network providers:

a) Notify providers of pending termination at least 30 90 days prior to removal from network.

b) Give to providers, at least 14 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. (Modify Current HOD Policy)

Resolution 809 asks that our AMA amend Policy H-285.908 by addition to state that our AMA supports requiring that health insurers that terminate in-network providers notify providers of pending termination at least 30 days prior to removal from network; and give to providers, at least 14 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status.

Your Reference Committee heard mixed testimony on Resolution 809. Speakers supported different notice periods before provider terminations without cause. A member of the Council on Medical Service noted that a recent Council report established Policy H-285.908 which is proposed to be amended by Resolution 809, but noted that two other policies – Policies H-285.952 and H-285.991 – address the intent of the resolution. The Council member underscored that existing policy that supports a 60-day threshold for notice to physicians is more stringent than the 30-day recommendation included in Resolution 809. Your Reference Committee notes that AMA's model state legislation on network adequacy already includes a 60-day policy specifically on network terminations. Your Reference Committee agrees that Policies H-285.952 and H-285.991 address the intent of Resolution 809, believes a 60-day policy on network terminations remains appropriate, and as such recommends that the policies be reaffirmed in lieu of Resolution 809.

H-285.952, Amendments to Managed Care Contracts

1. It is policy of the AMA that: (A) participating physicians be allowed a minimum of 60 days to review amendments to managed care contracts; (B) patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of/restrictions on their license/certification or fraud. Patients eligible for transitional care should specifically include, but not be limited to those who are: undergoing a course of treatment for a serious or complex condition, undergoing a course of institutional or inpatient care, undergoing non-elective surgery, pregnant, or are terminally ill at the time that they receive notice of the termination. Transitional care should be provided at the physicians' and hospitals' discretion, and should continue for an appropriate length of time. Physicians and hospitals also should continue to receive payment for the services provided during this transitional period; (C) when a participating physician leaves a managed care plan, patients of the physician be informed, in a timely manner, of the departure by the physician and/or the managed care plan, and, if applicable, of their right to elect continued transitional care from that physician; (D) when a participating physician voluntarily leaves a managed care plan, patients of the physician be informed of the departure by the physician and/or the managed care plan; (E) the AMA opposes managed care plan mandating that physician to notify all his/her patients; (F) the AMA opposes the preapproval of physician-developed notification letters by managed care plans required if a participating physician who is voluntarily leaving the plan chooses to inform his/her patient of the departure; and (G) managed care contracts not hold participating physicians financially liable for medical services delivered to a patient who electively chooses or mistakenly receives medical services from a "non-plan" physician. 2. Our AMA supports patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Transitional care should be provided at the physicians' and hospitals' discretion. 3. Our AMA will continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure continuity of care protections for patients in an active course of treatment. (Sub. Res. 708, I-96; Appended and Modified: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 4, A-12; Appended: CMS Rep. 03, A-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)

(26) RESOLUTION 822 - ELIMINATION OF ALL COST-SHARING FOR SCREENING COLONOSCOPIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992 be reaffirmed in lieu of Resolution 822.

HOD ACTION: Resolution 822 referred with report back at the 2018 Annual Meeting.

Resolution 822 asks that our AMA develop model national policy that supports the voluntary removal of all cost-sharing associated with screening colonoscopies in all commercial and Medicare Advantage product lines and advocates for the adoption of these policies nationwide.

Your Reference Committee heard mixed testimony on Resolution 822. A member of the Council on Medical Service called for reaffirmation of existing policies on coverage of preventive services, including colonoscopies, in lieu of Resolution 822, noting that these policies address the intent of the resolution. A member of the Council on Legislation also supported reaffirmation of policy in lieu of Resolution 822, noting that AMA advocacy efforts have called for requiring Medicare to waive the coinsurance for colorectal screening tests, regardless of whether therapeutic intervention is required during the procedure, and last month submitted letters to the sponsors of the relevant House and Senate bills in support of their legislation. Your Reference Committee agrees that existing policy enables the AMA to advocate on the issues raised in Resolution 822, while noting that under the ACA, screening colonoscopies that are provided in-network are required to have no cost-sharing. As such, your Reference Committee recommends that Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992 be reaffirmed in lieu of Resolution 822.

H-165.840, Preventive Medical Care Coverage for All

Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community. (Res. 827, I-08; Reaffirmed in lieu of Res. 107, A-12; Reaffirmed: Res. 123, A-17)

H-185.954, Coverage for Certain Types of Well Care Examinations by Health Insurers

Our AMA: (1) will continue to facilitate the education of the American public and physicians as to the benefits of clinical preventive services, such as mammography screening and periodic physical examinations; (2) will continue to evaluate on a regular basis the benefits and cost-effectiveness of clinical preventive services guidelines; and (3) urges all health insurers to make available for purchase a wide variety of group and individual health insurance policies that provide coverage for a range of clinical preventive services. (Sub. Res. 108, A-97; Modified: CMS Rep. 7, A-00; Reaffirmed: CMS Rep. 3, A-02; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 107, A-12)

H-185.960, Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans

Our AMA supports health plan coverage for the full range of colorectal cancer screening tests. (Res. 726, I-04; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: Res. 123, A-17)

H-425.987, Preventive Medicine Services

1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services. 2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review. (CMS Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmed and Appended: Res. 804, I-11; Reaffirmed in lieu of Res. 107, A-12; Reaffirmed: Res. 123, A-17)

H-425.992, Coverage of Preventive Medical Services by Medicare

The AMA advocates revision of current Medicare guidelines to include coverage of appropriate preventive medical services. (Res. 85, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-99; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 123, A-17)

(27) RESOLUTION 826 - IMPROVING AFFORDABILITY OF INSULIN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-110.987, H-125.977, H-125.979, H-185.939 and H-450.938 be reaffirmed in lieu of Resolution 826.

HOD ACTION: Resolution 826 referred with report back at the 2018 Annual Meeting.

Resolution 826 asks that our AMA work with relevant medical specialty societies to convene a summit with participation by patients, clinicians, manufacturers, PBMs, insurers and the appropriate federal representatives to highlight the dramatic increase in insulin costs and identify potential solutions; pursue solutions to reduce patient cost-sharing for insulin and ensure patients benefit from rebates at the point of sale; work with health insurance companies and federal agencies to stabilize drug formularies and reduce non-medical switching by encouraging plans to cover insulin products at the same cost listed on a drug formulary throughout the entire plan year; encourage insulin price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies; and work with electronic medical record vendors and insurance companies to integrate current formularies and price information into all systems so physicians and patients can make informed decisions on insulin products to reduce cost burdens on patients.

Your Reference Committee heard mixed testimony on Resolution 826. Testimony raised concerns with the price of insulin increasing 240 percent over the past decade. However, other speakers noted that insulin is not the only drug to experience noteworthy price increases; numerous other generic, brand and specialty drugs impacting a wide swath of patients also have had significant price increases. For example, your Reference Committee notes that between 2010 and 2015, Metformin HCl 850 mg tablet had a 574.7 percent retail price increase. The retail price of a 1-year supply of Truvada 200 mg-300 mg tablets increased from \$8,977 in 2006 to \$16,811 in 2015. Between 2010 and 2015, Sun Pharmaceutical's doxycycline hyclate 100 mg tablets increased by 1,788.9 percent and Actavis'

doxycycline hyclate 100 mg capsules increased by 1,244.2 percent. In addition, between 2010 and 2015, Divalproex sodium ER 500 mg tablet had a 450.6 percent price increase. Wellbutrin XL 300 mg tablets had a retail price increase of 1,185 percent over the 10-year period ending in 2015.

Members from the Council on Medical Service and the Council on Legislation underscored that the AMA needs to continue to take a comprehensive approach to drug pricing, versus singling out individual drugs, and that AMA advocacy can be more effective with a comprehensive approach. As such, speakers rose in support of reaffirmation, noting that existing policies address the intent and spirit of Resolution 826. Your Reference Committee agrees, and recommends that Policies H-110.987, H-125.977, H-125.979, H-185.939 and H-450.938 be reaffirmed in lieu of Resolution 826.

H-110.987, Pharmaceutical Costs

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients. 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17)

H-125.977, Non-Formulary Medications and the Medicare Part D Coverage Gap

Our AMA will advocate for: (1) the inclusion of out of pocket, non-formulary, prescription medication expenses in calculating a patient's contributions toward the Medicare Part D coverage gap, after which coverage resumes; and (2) economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured. (Res. 826, I-14; Reaffirmation I-15)

H-125.979, Private Health Insurance Formulary Transparency

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. 2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term. 3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term. 4. Our AMA will

promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours. 5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription. 6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans. (Sub. Res. 724, A-14; Appended: Res. 701, A-16)

H-185.939, Value-Based Insurance Design

Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles: a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements. b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists. c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan. d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients. e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design. f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties. h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence. i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972). (CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16; Reaffirmed: CMS-CSAPH Rep. 01, A-17)

H-450.938, Value-Based Decision-Making in the Health Care System

PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14)

REPORT OF REFERENCE COMMITTEE K

(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – PROMOTING AND REAFFIRMING DOMESTIC MEDICAL SCHOOL CLERKSHIP EDUCATION

RECOMMENDATION:

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

HOD ACTION: Council on Medical Education Report 1 adopted and the remainder of the report filed.

Council on Medical Education Report 1, in response to Resolution 308-I-16, considers concerns that have been raised about the availability of clinical clerkship training sites due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in the absolute numbers of U.S. medical schools—as well as the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions. The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 308-I-16 and the remainder of the report be filed:

1. That our American Medical Association (AMA):
 - 1) Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: a) infrastructure and faculty development and capacity for medical school expansion; and b) delivery of clinical clerkships and other educational experiences. (Directive to Take Action)
 - 2) Encourage clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students. (Directive to Take Action)
 - 3) Advocate for federal and state legislation/regulations to:
 - a. Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA);
 - b. Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and
 - c. Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA. (Directive to Take Action)
 - 4) Encourage relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. (Directive to Take Action)
 - 5) Work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students. (Directive to Take Action)
2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical

medicine, especially when the presence of visiting students would disadvantage the institution's own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites. (New HOD Policy)

3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas. (New HOD Policy)
4. U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA. (New HOD Policy)
5. Existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. (New HOD Policy)
6. That Policies H-255.988 (6, 23, 25), H-255.998, H-295.995 (30, 31), D-295.320, D-295.931, and D-295.937 be rescinded, as described in Appendix C to this report. (Rescind HOD Policy)

Your Reference Committee heard testimony in strong support of the work of the Council on Medical Education on this topic. The AMA's long and storied history of ensuring the highest quality of medical education is underscored by this report, which emphasizes the need for the continued availability of clinical clerkship training sites in the face of increased enrollment in U.S. allopathic and osteopathic medical schools, in the absolute number of U.S. medical schools, and the growing number of foreign medical schools that seek to place their students at U.S. institutions for their clinical clerkships. The overall quality of medical education in the United States could be compromised by having too many learners for the currently available capacity of the clerkship environment. Your Reference Committee recommends adoption as written.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – TARGETED EDUCATION TO INCREASE ORGAN DONATION

RECOMMENDATION:

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

HOD ACTION: Council on Science and Public Health Report 2 adopted and the remainder of the report filed.

Council on Science and Public Health Report 2 responds to Policy D-370.984 by reviewing current organ donation statistics, attitudes about donation, the disproportion between those needing a transplant and the organs available, factors influencing the decision to designate oneself as a donor, and educational interventions targeted to segments of the population with historically low rates of organ donation. The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed:

1. That Policy H-370.959, "Methods to Increase the US Organ Donor Pool," be amended by addition to read as follows:
In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs, including educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues. (Modify Current HOD Policy)
2. That Policy D-370.984 be rescinded, having been accomplished through this report. (Rescind HOD Policy)

Testimony was unanimously supportive of CSAPH 2, which evaluates both the factors influencing the decision to designate oneself as an organ donor and the educational interventions that have successfully targeted segments of

the population most in need to improve organ donation rates. A continuing need to address this issue and reduce existing disparities was noted. Your Reference Committee urges adoption of the report's recommendations.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 –
NEUROPATHIC PAIN AS A DISEASE

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.

HOD ACTION: Council on Science and Public Health Report 3 adopted and the remainder of the report filed.

Council on Science and Public Health Report 3 is in response to Resolution 912-I-16 and considers whether neuropathic pain should be recognized as a distinct disease state. The report discusses the complexities surrounding the issue and concludes that evaluating neuropathic pain as a distinct disease state would be best deliberated by a group of multi-specialty experts involved in the evaluation and treatment of pain who could more deeply focus on the topic and consider all of its ramifications. The Council on Science and Public Health recommends that the following statement be adopted in lieu of Resolution 912-I-16 and the remainder of the report be filed:

That the Federation Task Force on Pain Care evaluate the relative merits of declaring neuropathic pain as a distinct disease state, and provide a recommendation to the Council on Science and Public Health.

(Directive to Take Action)

The Council was thanked for developing this report, and general support was offered for their recommendation to have this issue further explored by the Federation-based Pain Care Task Force, which is in the process of being formed. The expertise that such a group will bring is important in evaluating this complex issue. Your Reference Committee concurs that the approach recommended is appropriate.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – NATIONAL DRUG SHORTAGES: UPDATE

RECOMMENDATION:

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

HOD ACTION: Council on Science and Public Health Report 4 adopted and the remainder of the report filed.

Council on Science and Public Health Report 4 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 report provides an update on continuing trends in national drugs shortages and ongoing efforts to further evaluate and address this critical public health issue. The Council has issued seven previous reports on drug shortages and this report updates information on drug shortages since the 2016 report was developed. The Council on Science and Public Health recommends that Policy H-100.956 be amended by addition to read as follows and the remainder of the report be filed:

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 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 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)

The Council was thanked for their continuing attention to this critical issue, and strong support was expressed for the report and its recommendation. Testimony noted the damage that had occurred to multiple pharmaceutical manufacturing sites in Puerto Rico and how that could potentially worsen an already fragile supply of critical medications. The Council acknowledged that several new concerns have been identified that need to be further examined and pledged to supply an updated report at A-18. Some concern was expressed about physicians being able to get current information about drugs that are in short supply; specific resources and mobile apps are available to help with that process. A request also was made to further examine the role of group purchasing organizations in drug shortages. The Council recommends adopting the current report to address issues that may impact mergers and acquisitions in the pharmaceutical industry, and promises to return an updated report to the House in June. Your Reference Committee concurs.

(5) RESOLUTION 910 – IMPROVING TREATMENT AND DIAGNOSIS OF
MATERNAL DEPRESSION THROUGH SCREENING AND STATE-BASED
CARE COORDINATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 910 be adopted.

HOD ACTION: Resolution 910 adopted.

Resolution 910 asks that our American Medical Association 1.) work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; 2.) encourage the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and 3.) encourage the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

Testimony noted the large public health burden attributable to prenatal and postnatal depression and the availability of resources from the National Institutes of Health for physician offices and clinics to raise awareness of this issue. Virtually unanimous testimony was offered in support of this resolution. Some debate centered on the wisdom of the third resolve, and whether it represents an unfunded mandate. A public law exists around establishing a screening and treatment program for maternal depression that would establish state-based grant programs for improving screening and treatment for pregnant and postpartum women experiencing maternal depression, but it is unfunded. Existing AMA policy already supports (1) improvements in mental health services for women during pregnancy and postpartum, (2) advocacy for insurance coverage of mental health services up to one year postpartum, and (3) organizations working to improve education and awareness of the risks of mental illness during gestation and postpartum. In the absence of further information, your Reference Committee recommends adopting the resolution.

(6) RESOLUTION 911 – STATE MATERNAL MORTALITY REVIEW COMMITTEES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 911 be adopted.

HOD ACTION: Resolution 911 adopted.

Resolution 911 asks that our AMA 1.) support the important work of maternal mortality review committees. 2.) support work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and 3.) support work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

Your Reference Committee heard testimony unanimously supportive of Resolution 911. Among developed countries, the United States has the highest maternal mortality rate. Significant disparities exist in maternal mortality rates among different racial groups. There is broad support in the maternal and child health community for the investigation of maternal deaths by a multi-disciplinary Maternal Mortality Review committee. Therefore, your Reference Committee recommends that Resolution 911 be adopted.

(7) RESOLUTION 913 – INCREASED DEATH RATE AND DECREASED LIFE EXPECTANCY IN THE UNITED STATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 913 be adopted.

HOD ACTION: Resolution 913 adopted.

Resolution 913 asks that our American Medical Association 1.) raise awareness of the recent reversals in the improvement of overall death rates and life expectancy with the message that these new problems in the United States are different from all other developed countries and that these trends need to be reversed promptly; 2.) call on the legislative and executive branches of the Federal Government to fund and carry out investigations into the causes of these very unusual decreases in life expectancy and increases in death rates in order to design multi-disciplinary interventions to reverse these troubling changes; and 3.) encourage state and local medical societies to raise awareness of the new problems of decreasing life expectancy and increasing population death rates as indicators of major public health problems and advocate for local investigation of the causes and remedies for these disturbing problems.

Your Reference Committee heard a significant amount of testimony regarding this resolution. Many agreed with the sentiment of the resolution and noted that no current AMA policy exists on this topic. Many also supported further investigations into the causes of increased death rates and specifically noted increases in opioid mortality and

suicide, and health equity variations by Zip code. Therefore, your reference committee recommends that Resolution 913 be adopted.

(8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 –
UNIVERSAL COLOR SCHEME FOR RESPIRATORY INHALERS

RECOMMENDATION A:

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

Our American Medical Association supports research into mechanisms to improve patient understanding of their respiratory inhaler medications with the aim of improving safety and reducing unintentional medication errors, such as inhaler skills training, and individualized action plans, and distinctive packaging features for rescue inhalers. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Council on Science and Public Health Report 1 adopted as amended and the remainder of the report filed.

Council on Science and Public Health Report 1, in response to Resolution 906-I-16, notes the limited evidence supporting color coding systems to reduce medication errors in outpatients. The disadvantages of using color coding systems are cited and experts, including the FDA, either oppose color coding or recommend caution in its application. Experts evaluating the adherence of patients using inhalers have suggested that individualized counseling with personalized action plans and inhaler skills training are the best approach for improving adherence. The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 906-I-16, “Universal Color Scheme for Respiratory Inhalers,” and the remainder of the report be filed:

Respiratory Inhaler Medications

Our American Medical Association supports research into mechanisms to improve patient understanding of their respiratory inhaler medications with the aim of improving safety and reducing unintentional medication errors, such as inhaler skills training and individualized action plans. (New HOD Policy)

The Council was thanked for their work on this important topic. Considerable testimony was supportive of the Council’s report and the recommendation that was offered. Testimony was also offered supporting the color coding of rescue inhalers. Your Reference Committee understands that the Food and Drug Administration does not support color coding for a host of reasons, including colorblind patients, and that there is limited evidence to support the color coding of pharmaceutical products, but notes that other distinctive packaging features could be utilized to distinguish rescue inhalers from other inhalers and supports this research. Additionally, testimony was provided regarding the unintended consequences including the potential increased cost that could be passed on to consumers if pharmaceutical manufacturers were required to change product color. Therefore, your reference committee recommends that the recommendation in Council on Science and Public Health Report 1 be adopted as amended.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 – CLINICAL IMPLICATIONS AND POLICY CONSIDERATIONS OF CANNABIS

RESOLUTION 915 – EASING BARRIERS TO MEDICAL RESEARCH ON MARIJUANA DERIVATIVES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation 1 in Council on Science and Public Health Report 5 be amended by addition and deletion to read as follows:

1. That portions of Policies H-95.998, “AMA Policy Statement on Cannabis,” H-95.995 “Cannabis Use,” H-95.938 “Immunity from Federal Prosecution for Physicians Recommending Cannabis,” and D-95.976 “Cannabis – Expanded AMA Advocacy,” be retained and used, in part, to establish the following new policies:

Cannabis Legalization for Recreational Use

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for recreational use should not be legalized; (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (3) believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use; (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use. (New HOD Policy)

Cannabis Legalization for Medicinal Use

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) opposes believes that the legalization of cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; and (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Science and Public Health Report 5 be amended by addition to read as follows:

1. That Policy H-95.952, “Cannabis for Medicinal Use,” be amended by addition and deletion to read as follows:

H-95.952, “Cannabis and Cannabinoid Research for Medicinal Use”

- (1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. (5) Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. (Modify 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 in lieu of Resolution 915 and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 5 adopted as amended in lieu of Resolution 915 and the remainder of the report filed.

Council on Science and Public Health Report 5 responds to Resolution 907-I-16, introduced by the Resident and Fellow Section and referred by the House of Delegates. Resolution 907 asked that our AMA amend existing policies, however, the evidence available at this time does not support a substantial change in the AMA's policy on cannabis. Ongoing surveillance to determine the impact of cannabis legalization and commercialization on public health and safety will be critical. The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 907-I-16 and the remainder of the report be filed:

1. That portions of Policies H-95.998, "AMA Policy Statement on Cannabis," H-95.995 "Cannabis Use," H-95.938 "Immunity from Federal Prosecution for Physicians Recommending Cannabis," and D-95.976 "Cannabis – Expanded AMA Advocacy," be retained and used, in part, to establish the following new policies:

Cannabis Legalization for Recreational Use

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for recreational use should not be legalized; (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (3) believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use; (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use. (New HOD Policy)

Cannabis Legalization for Medicinal Use

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) opposes the legalization of cannabis for medicinal use through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process. "; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; and (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (New HOD Policy)

2. That the following new policy be adopted:

Taxes on Cannabis Products

Our AMA encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts. (New HOD Policy)

3. That Policy H-95.952, "Cannabis for Medicinal Use," be amended by addition and deletion to read as follows:

H-95.952, "Cannabis Research for Medicinal Use"

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for

cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. (5) Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. (Modify Current HOD Policy)

4. That Policy H-95.936, "Cannabis Warnings for Pregnant and Breastfeeding Women," be reaffirmed. (Reaffirm HOD Policy)
5. That Policies H-95.998, "AMA Policy Statement on Cannabis," H-95.995, "Cannabis Use," H-95.938, "Immunity from Federal Prosecution for Physicians Recommending Cannabis," and D-95.976, "Cannabis – Expanded AMA Advocacy," be rescinded since they have been implemented, were duplicative of another policy, or portions were incorporated into new policies proposed in this report. (Rescind HOD Policy)

Resolution 915 asks that our American Medical Association work with the National Institutes of Health to advocate for easing the barriers to medical research regarding chemical components of marijuana such as cannabidiol that show great promise.

Your Reference Committee heard testimony that was largely supportive of the Council's recommendations on cannabis. Those in support of the Council's recommendations noted that cannabis products for medicinal use should be approved by the FDA and not through the state legislative or ballot measure process. Limited testimony questioned whether cannabis is a dangerous drug and noted concern with the AMA opposing the legalization of cannabis for medicinal purposes through the state legislative or ballot measure process. Your Reference Committee agreed that the word "oppose" could be modified while still capturing the original intent of the statement. There was broad support for continued research on the health effects of cannabis, public health surveillance in states that have legalized cannabis use, and allocating cannabis tax revenue to public health programs. Your Reference Committee believes that Resolution 915 is covered in existing Policy H-95.952 on cannabis research, but supports amending the title of that policy to better reflect our AMA's advocacy for easing barriers to medical research regarding cannabinoids, such as cannabidiol. Therefore, your Reference Committee recommends that the recommendations in CSAPH Report 5 be adopted as amended in lieu of Resolution 915.

(10) RESOLUTION 901 – HARMFUL EFFECTS OF SCREEN TIME IN CHILDREN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 901.

HOD ACTION: The following resolution adopted in lieu of Resolution 901.

RESOLVED, That our AMA encourage primary and secondary schools to incorporate into health class curriculum the topic of balancing screen time with physical activity and sleep; (New HOD Policy) and be it further

RESOLVED, that our AMA encourage primary care physicians to assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits. (New HOD Policy)

Resolution 901 asks that our American Medical Association 1.) encourage all schools to incorporate into health class curriculum the topic of balancing screen time with physical activity and sleep; 2.) encourage research into the utility of blue light filtering glasses and a blue light filter option on devices such as smart phones and tablets; and 3.) encourage physicians to assess all patients and educate all parents about amount of screen time, physical activity and sleep habits.

Your Reference Committee heard testimony detailing the need for increased physical activity and the importance of balancing the amount of time spent viewing digital devices and being active, and the need to incorporate this education into schools. An alternative resolution was offered by the sponsors and was largely supported. Therefore, your Reference Committee recommends that alternate Resolution 901 be adopted.

(11) RESOLUTION 902 – EXPANDING EXPEDITED PARTNER THERAPY TO TREAT TRICHOMONIASIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 902 be amended by addition and deletion to read as follows:

H-440.868, Expedited Partner Therapy

Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, and/or chlamydia, and/or Trichomoniasis infection, and other sexually transmitted infections, as supported by scientific evidence and identified by the CDC. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 902 be adopted as amended.

HOD ACTION: Resolution 902 adopted as amended.

Resolution 902 asks that our American Medical Association amend Policy H-440.868 by addition and deletion to read as follows:

H-440.868 Expedited Partner Therapy

Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, and/or chlamydia, and/or Trichomoniasis infection.

Your Reference Committee heard testimony supportive of Resolution 902. Since Trichomoniasis is easily treatable with a single dose of antibiotics there was support for the use of expedited partner therapy (EPT). The CDC's 2015 sexually transmitted diseases treatment guidelines suggest that EPT might have a role in partner management for Trichomoniasis. However, no single partner management intervention has been shown to be more effective than any other in reducing Trichomoniasis reinfection rates. An amendment was proposed to include other STIs as identified by the Centers for Disease Control to preclude having to add additional STIs as more evidence becomes available. Your Reference Committee believes that supporting the use of EPT for STIs, as supported by scientific evidence and the CDC, accomplishes the intent of the resolution. Therefore, Your Reference Committee recommends that Resolution 902 be adopted as amended.

(12) RESOLUTION 903 – IMPROVING SCREENING AND TREATMENT GUIDELINES FOR DOMESTIC VIOLENCE AGAINST LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING, AND OTHER INDIVIDUALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 903 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study publish an update to its 1992 Diagnostic and Treatment Guidelines on Domestic Violence to reflect recent domestic violence data and to address the unique issues faced by the LGBTQ+ population~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 903 be amended by deletion to read as follows:

RESOLVED, That our AMA promote crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 903 be amended by deletion to read as follows:

RESOLVED, That our AMA amend AMA Policy H-65.976 by addition to read as follows:

Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement (Modify Current HOD Policy); and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 903 be amended by deletion to read as follows:

RESOLVED, That our AMA amend AMA policy H-160.991 by addition and deletion to read as follows:

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.9911. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, and transgender, queer/questioning, and other (LGBTQ+) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ+; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ+ Health

and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ+ patients; (iii) encouraging the development of educational programs in LGBTQ+ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ+ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ+ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ+ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.² Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.³ Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ+ health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ+ people. (Modify Current HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 903 be adopted as amended.

HOD ACTION: Resolution 903 adopted as amended.

Resolution 903 asks that our American Medical Association 1.) publish an update to its 1992 Diagnostic and Treatment Guidelines on Domestic Violence to reflect recent data and to address unique issues faced by the LGBTQ+ population; 2.) promote crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence; 3.) amend AMA Policy H-65.976 by addition to read as follows:

Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement and 4.) amend AMA policy H-160.991 by addition and deletion to read as follows:

H-160.991, Health Care Needs of Lesbian Gay Bisexual and Transgender Populations

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, and transgender, queer/questioning, and other (LGBTQ+) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ+; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ+ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ+ patients; (iii) encouraging the development of educational programs in LGBTQ+ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ+ people so that all physicians will achieve

a better understanding of the medical needs of these populations; and (v) working with LGBTQ+ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ+ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ+ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ+ people.

Your Reference Committee heard testimony largely in support of Resolution 903. It was recognized that many groups within the LGBTQ population experience intimate partner violence at least as frequently as heterosexual women, who are the focus of most screening and intervention efforts. The sponsors offered an amendment to the first Resolve statement encouraging the AMA to study the issue rather than revise the 1992 guidelines. Your Reference Committee agrees with that amendment. Your Reference Committee also agrees with using the term LGBTQ rather than LGBTQ+, to be consistent with AMA policy per the testimony from the AMA LGBTQ advisory committee stating that there is a lack of consensus on use of the plus sign at this time. Therefore, your Reference Committee recommends that Resolution 903 be adopted as amended.

(13) RESOLUTION 904 – EDUCATING PHYSICIANS ABOUT THE IMPORTANCE OF CERVICAL CANCER SCREENING FOR FEMALE-TO-MALE TRANSGENDER PATIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 904 be amended by addition and deletion to read as follows:

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals women who have sex with women and female to male transgender patients when medically indicated to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 904 be adopted as amended.

HOD ACTION: Resolution 904 adopted as amended.

Resolution 904 asks that our American Medical Association amend Policy H-160.991 by addition to read as follows:

H-160.991, Health Care Needs of Lesbian Gay Bisexual and Transgender Populations
 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women and female-to-male transgender patients when medically indicated to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.

Your Reference Committee heard testimony unanimously in support in this resolution. Comments detailed the high rate of cervical cancer risk for individuals with a cervix. An amendment was offered to focus on anatomy rather than listing of possible individuals, with which your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 904 be adopted as amended.

(14) RESOLUTION 905 – ADDRESSING SOCIAL MEDIA USAGE AND ITS NEGATIVE IMPACTS ON MENTAL HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 905 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association collaborate with relevant professional organizations to (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media usage, and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended.

HOD ACTION: Resolution 905 adopted as amended.

Resolution 905 asks that our American Medical Association collaborate with relevant professional organizations to (a) develop continuing education programs to enhance physicians' knowledge of the health impacts of social media usage, and (b) develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; and that our AMA advocate for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media usage.

Your Reference Committee heard testimony largely in support of Resolution 905. Many commenters spoke of broad health impacts, both negative and positive and not just mental health related, from social media usage, as well as social media over-use. The idea of education programs was well-received. However, many commented that our AMA developing clinical tools and protocols is outside of the scope of the organization and are tasks that are better suited for specialized organizations. Therefore, your Reference Committee recommends that Resolution 905 be adopted as amended.

(15) RESOLUTION 906 – OPIOID ABUSE IN BREASTFEEDING MOTHERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 906 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association's Opioid Task Force to ~~Reduce Opioid Abuse~~ promote educational resources for opioid dependent mothers who are breastfeeding on the benefits and risks of breastfeeding while using prescription opioids drugs or during medication-assisted maintenance therapy for opioid use disorder, based on the most recent guidelines.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 906 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 906 be changed to read as follows:

BREASTFEEDING IN MOTHERS WHO USE OPIOIDS

HOD ACTION: Resolution 906 adopted as amended with a change in title.

Resolution 906 asks that our American Medical Association's Task Force to Reduce Opioid Abuse promote educational resources for opioid dependent mothers on the benefits and risks of breastfeeding while using opioid drugs or during maintenance therapy based on the most recent guidelines; and that our AMA amend by addition existing AMA Policy H-420.962, "Perinatal Addiction - Issues in Care and Prevention," to read as follows:

H-420.962, Perinatal Addiction - Issues in Care and Prevention

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

Consistent and compelling testimony was offered in support of this resolution. Several members noted the importance of providing evidence-based care for the treatment of opioid use disorder in women of childbearing age and in those who are pregnant or breastfeeding. Clear guidance exists to assist clinical decision-making in such patients. The benefits that accrue from breastfeeding in this population are established, but a significant educational gap is apparent, and disparities are common. A suggestion was made to expand the topic of this resolution to specifically include incarcerated populations. While an important issue, your Reference Committee believes it has other dimensions that need to be considered. Your Reference Committee recommends adoption with some editorial and terminology changes, as well as a change in title.

(16) RESOLUTION 907 – ADDRESSING HEALTHCARE NEEDS OF FOSTER CHILDREN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 907 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care ~~system children~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 907 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 907 be changed to read as follows:

ADDRESSING HEALTHCARE NEEDS OF CHILDREN IN FOSTER CARE

HOD ACTION: Resolution 907 adopted as amended with a change in title.

Resolution 907 asks that our American Medical Association advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children.

Your Reference Committee heard testimony unanimously in support of this resolution. It was noted that there are more than 400,000 children in foster care and that advocacy is needed to help this population. Therefore, your Reference Committee recommends that Resolution 907 be adopted as amended.

(17) RESOLUTION 908 – UPDATING ENERGY POLICY AND EXTRACTION REGULATIONS TO PROMOTE PUBLIC HEALTH AND SUSTAINABILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 908 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support research on the implementation of buffer zones or well set-backs between oil and gas development sites and residences, schools, hospitals, and religious institutions, to determine the distance necessary to ensure public health and safety. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 908 be adopted as amended.

HOD ACTION: Resolution 908 adopted as amended.

Resolution 908 asks that our AMA amend policy H-135.949 by insertion and deletion to read as follows:

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, ~~substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development, promotion, and widespread implementation~~ of alternative renewable energy sources in lieu of carbon-based fossil fuels.

and that our AMA support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions.

Your Reference Committee heard mostly supportive testimony on Resolution 908. Some concerns were raised regarding buffer zones and the lack of data available on the minimum well set-backs necessary to protect public health and safety. Your Reference Committee agrees that more research is needed and therefore recommends that Resolution 908 be adopted as amended.

(18) RESOLUTION 909 – EXPANDING NALOXONE PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 909 be amended by addition to read as follows:

RESOLVED, That our American Medical Association urge the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions). (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 909 be adopted as amended.

HOD ACTION: Resolution 909 adopted as amended.

Resolution 909 asks that our American Medical Association study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

Substantial testimony was expressed for the concept of this resolution, and the value of having the AMA study the issue in an effort to move it forward. The AMA already has strong policy in support of expanded access to naloxone through community-based efforts, physician standing orders, and co-prescribing. An analogy with community-based external automated defibrillators was advanced. While this concept is appealing, given the need to expand access to naloxone in this country, several potential barriers and requisite steps were noted, including: (1) the need for the FDA to regulate this practice and approve over-the-counter availability of a naloxone product that would be suitable for placement in a public setting and amenable to untrained bystander use; (2) a requirement for stability testing, expiration dating, and product replacement; (3) the need to place the product for maximum effectiveness; and, (4) security requirements appropriate to a publicly available antidote that is in high demand and expensive. For all these reasons, your Reference Committee believes a cycle of FDA review would be prudent before committing AMA resources to evaluating or attempting to understand how such a program might be implemented.

(19) RESOLUTION 912 – CORRECTIVE STATEMENTS ORDERED TO BE PUBLISHED BY TOBACCO COMPANIES FOR THE VIOLATION OF THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 912 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association collaborate with state and medical specialty societies members, component societies, and other interested public health organizations such as the Campaign for Tobacco Free Kids, Truth Initiative, the American Cancer Society, the American Lung Association and the American Heart Association, to help educate the public and policymakers about the tobacco companies' organized conspiracy to commit fraud leading to the federal court verdict finding them in violation of the Racketeer Influenced and Corrupt Organization Act (RICO) and resulting in the corrective statements as ordered by the U.S. Court of Appeals in *United States v. Philip Morris* (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 912 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage state and medical specialty-our component societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly-influenced by tobacco companies or their lobbyists and encourage lawmakers to remediate all such influences, to reject any potential tobacco industry influences in the future, and to formally censure the tobacco companies for their fraudulent and harmful behavior. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 912 be adopted as amended.

HOD ACTION: Resolution 912 adopted as amended.

Resolution 912 asks that our American Medical Association collaborate with members, component societies, and other interested public health organizations such as the Campaign for Tobacco Free Kids, Truth Initiative, the American Cancer Society, the American Lung Association and the American Heart Association, to help educate the public and policymakers about the tobacco companies' organized conspiracy to commit fraud leading to the federal court verdict finding them in violation of the Racketeer Influenced and Corrupt Organization Act (RICO) and resulting in the corrective statements as ordered by the U.S. Court of Appeals in United States vs. Philip Morris; and that our AMA encourage our component societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly influenced by tobacco companies or their lobbyists and encourage lawmakers to remediate all such influences, to reject any potential tobacco industry influences in the future, and to formally censure the tobacco companies for their fraudulent and harmful behavior.

Your Reference Committee heard testimony in strong support of Resolution 912. Due to RICO violations, cigarette manufacturers will begin making corrective statements on topics about which they had historically deceived the public. The content of these corrective statements has been the subject of litigation for nearly two decades. This resolution will help raise awareness regarding these corrective statements. The amendments remove reference to any

specific stakeholder organizations and clarify that the term component societies refers to state and medical specialty societies. Therefore, your Reference Committee recommends that Resolution 912 be adopted as amended.

(20) RESOLUTION 914 – SUPPORT OF TRAINING, ONGOING EDUCATION, AND CONSULTATION IN ORDER TO REDUCE THE HEALTH IMPACT OF PEDIATRIC ENVIRONMENTAL CHEMICAL EXPOSURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 914 be amended by deletion of the third Resolve.

~~RESOLVED, That our AMA encourage the continuing training of physicians specializing in pediatric environmental health. (New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 914 be adopted as amended.

HOD ACTION: Resolution 914 adopted as amended.

Resolution 914 asks that our American Medical Association 1.) support the mission of and ongoing funding of academically-based regional Pediatric Environmental Health Specialty Units (PEHSU) by the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention (ATSDR/CDC) and the Environmental Protection Agency (EPA); 2.) support educational and consultative activities of the PEHSU program with local pediatricians, medical toxicologists, obstetricians, and others providing care to pregnant patients; and 3.) encourage the continuing training of physicians specializing in pediatric environmental health.

Limited but supportive testimony was offered on this resolution. A recommendation was made to delete the third resolve to avoid a continual evolution of specific training requests that may be submitted to the House of Delegates for deliberation. Your Reference Committee concurs.

(21) RESOLUTION 916 – HOSPITAL DISASTER PLANS AND MEDICAL STAFFS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 916 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA: (1) ~~work with~~ encourage appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) encourage hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 916 be adopted as amended.

HOD ACTION: Resolution 916 adopted as amended.

Resolution 916 asks that our American Medical Association: (1) work with appropriate stakeholders to examine the barriers and facilitators that medical staffs encounter following a natural or other disaster; and (2) encourage

hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff response during a natural or other disaster, both within their institutions and across the community.

Your Reference Committee heard limited, but supportive testimony for Resolution 916. There was consensus that people need to be involved in planning before disaster strikes and current AMA policy does not address personal preparedness for medical staffs. Your Reference Committee is aware that there are multiple stakeholders engaged and working in this area already. The AMA is best suited to encourage them to address these issues. Therefore your Reference Committee recommends that 916 be adopted as amended.

(22) RESOLUTION 952 – IMPLICIT BIAS, DIVERSITY AND INCLUSION IN MEDICAL EDUCATION AND RESIDENCY TRAINING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 952 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association: (1) actively support the development and implementation of training regarding implicit bias, diversity and inclusion as a component of medical education in all medical schools and residency programs; (2) identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk according to race and ethnicity, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (3) support research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes according to race and ethnicity, in all at-risk populations. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 952 be adopted as amended.

HOD ACTION: Resolution 952 adopted as amended.

Resolution 952 asks that our American Medical Association: (1) actively support the development and implementation of training implicit bias, diversity and inclusion as a component of medical education in all medical schools and residency programs; (2) identify and publicize effective strategies for educating residents in all specialties about disparities in their fields according to race and ethnicity, with particular regard to access to care and health outcomes; and (3) support research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes according to race and ethnicity.

Your Reference Committee heard universally supportive testimony for the intent of Resolution 952. Delegates noted the importance of recognizing the effects of implicit bias, diversity, and inclusion, and stressed the urgent need to address these concerns at multiple levels. Testimony also recognized the work currently being done in this area by members of the AMA's Accelerating Change in Medical Education consortium. Additional testimony elicited the fact that biases can be bidirectional in nature, and that patients and lay caregivers can also harbor/be affected by these types of biases.

Testimony heard in Reference Committee is in line with existing AMA policy. Policy H-350.974, "Racial and Ethnic Disparities in Health Care," recognizes racial and ethnic health disparities as a major public health problem in the United States; Policy H-295.897, "Enhancing the Cultural Competence of Physicians," encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency and the combining of knowledge of health disparities and practice of cultural competence with clinical skills; Policy 350.991, "Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities," encourages all members of

the federation to embrace principles related to ending care disparities; and D-350.996, “Strategies for Eliminating Minority Health Care Disparities,” asks our AMA to continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts.

Additional supportive policies include H-350.961, “Improving the Health of Minority Populations”; D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce”; H-350.970, “Diversity in Medical Education”; H-350.979, “Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession”; H-350.960, “Underrepresented Student Access to US Medical Schools”; D-350.995, “Reducing Racial Ethnic Disparities in Health Care”; and D-200.982, “Diversity in the Physician Workforce and Access to Care.”

Several friendly amendments were proposed, which your Reference Committee feels help to clarify and strengthen the resolution. Therefore, your Reference Committee recommends that Resolution 952 be amended by addition and deletion.

(23) RESOLUTION 953 – FEES FOR TAKING MAINTENANCE OF CERTIFICATION EXAMINATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-275.924 (19), Maintenance of Certification, be amended in lieu of Resolution 953 to read as follows:

HOD ACTION: Policy H-275.924, Maintenance of Certification, amended in lieu of Resolution 953 to read as follows:

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not be cost prohibitive or present a barrier to patient care.

27. That our AMA continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.

Resolution 953 asks that our American Medical Association request reductions in Maintenance of Certification examination fees so as to work towards a balanced/neutral budget of ABMS medical boards given their status as non-profit organizations.

Your Reference Committee heard mixed testimony related to the fee for the MOC Part III examination. Some felt that the cost of the examination was onerous and a burden for physicians, and that there was a lack of clinical relevance and evidence to support efficacy as well as high fees to participants. There was also concern about the equity of the fee structure of MOC established by the specialty boards, since some specialty boards have adopted or are considering the adoption of reduced fee structures for MOC, while other boards have not. Testimony also pointed out that due to the Council on Medical Education's continued dialogue and collaboration with the American Board of Medical Specialties and its member boards, there has been progress in addressing AMA member concerns about the MOC examination. About half of the ABMS member boards have taken steps to make the examination more constructive and less onerous for physicians. The boards are also addressing issues of convenience, relevance, and cost. This is a complex issue that the Council continues to proactively engage in with the member board community to achieve a more meaningful process for physicians and reports to the HOD annually. It was also noted that similar existing HOD policy could be modified to support the intent of this resolution. Therefore, your Reference Committee recommends that Policy H-275.924 (19), “Maintenance of Certification,” be amended in lieu of Resolution 953.

(24) RESOLUTION 954 – DEVELOPING PHYSICIAN LED PUBLIC
HEALTH/POPULATION HEALTH CAPACITY IN RURAL COMMUNITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 954 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study~~, with the participation of the appropriate educational and certifying entities, encourage the study of innovative approaches that could be developed and/or implemented to ~~promote support interested physicians to obtain board eligibility as they seek qualifications and credentials~~ in preventive medicine/public health to strengthen public health leadership, especially in rural communities.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 954 be adopted as amended.

HOD ACTION: Resolution 954 adopted as amended.

Resolution 954 asks that our American Medical Association study, with the participation of the appropriate educational and certifying entities, innovative approaches that could be developed and/or implemented to promote interested physicians to obtain board eligibility in preventive medicine/public health to strengthen public health leadership, especially in rural communities.

Your Reference Committee heard testimony in overall support of Resolution 954 and the need for flexible approaches to enhance the leadership of physicians in public health and preventive medicine. Additional testimony, while in support of the resolution's intent, reflected that the American Board of Preventive Medicine already has in place numerous alternative pathways to achieve these aims and ensure flexibility. Others noted that the need for leadership in public health is acute in urban as well as rural areas, and that more women are needed in these roles, in light of the panoply of health issues affecting female patients. Comments were also heard in opposition to the term "board eligibility." Your Reference Committee believes that the emendations proffered by the Council on Medical Education, and deletion of the term "board eligibility," strengthen this proposed policy, and thereby recommend adoption as amended.

(25) RESOLUTION 955 – MINIMIZATION OF BIAS IN THE ELECTRONIC
RESIDENCY APPLICATION SERVICE RESIDENCY APPLICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 955 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for the formation of an encourage the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Residency Application Bias Minimization Advisory Committee to develop steps to minimize bias in the ERAS and the examine this role of bias in residency training selection process (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 955 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for the modifications in of the ERAS Residency Application to minimize its bias consider the effects these changes may have on efforts to increase diversity in residency programs in accordance with the suggestions of the ERAS Residency Application Bias Minimization Committee. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 955 be adopted as amended.

HOD ACTION: Resolution 955 adopted as amended.

Resolution 955 asks that our American Medical Association advocate for the formation of an Electronic Residency Application Service (ERAS) Residency Application Bias Minimization Committee to examine this role of bias in residency training selection process; and that our AMA advocate for the modification of the ERAS Residency Application to minimize its bias in accordance with the suggestions of the ERAS Residency Application Bias Minimization Committee.

Your Reference Committee heard strong support for the intent of this resolution, and many stressed the AMA's ability to send a message of support for minimization of bias and enhancement of diversity in the physician workforce. Existing AMA policy is supportive of the intent of Resolution 955. Policies H-310.976, "Gender-Based Questioning in Residency Interviews," D-255.982, "Oppose Discrimination in Residency Selection Based on International Medical Graduate Status," and H-310.919, "Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process," oppose residency interview questions/candidate selection based on gender, IMG status, marital status/plans for marriage or children, sexual orientation, age, race, national origin, and religion. D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce," states that the AMA will work to advocate for tracking and reporting of demographic information pertaining to underrepresented minority status collected by the ERAS applications through the NRMP. D-310.977, "National Resident Matching Program Reform," states that our AMA will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants.

Testimony did elicit that the AAMC has an existing ERAS Advisory Committee, and it was felt that it would be appropriate for this existing body, not a new group, to develop steps to minimize bias in the ERAS and residency training selection process. A friendly amendment was suggested to acknowledge the existence of this committee. A second amendment was proffered that any proposed modifications be reviewed to consider the effects these changes might have on efforts to increase diversity in residency programs.

Referral was mentioned as a possible option, because of the complexity of this topic. However, your Reference Committee feels that as an appropriate body located within the AAMC already exists to address these types of issues, the AMA does not need to perform its own, separate study. Therefore, your Reference Committee recommends that Resolution 955 be adopted as amended.

(26) RESOLUTION 957 – STANDARDIZATION OF FAMILY PLANNING TRAINING OPPORTUNITIES IN OB-GYN RESIDENCIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 957 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology

and the American Congress of Obstetricians and Gynecologists' recommendations. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 957 be adopted as amended.

HOD ACTION: Resolution 957 adopted as amended.

Resolution 957 asks that our American Medical Association encourage the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the American Congress of Obstetricians and Gynecologists' recommendations.

Your Reference Committee heard testimony universally in support of the intent of this resolution. Multiple delegations stressed the importance of high-quality training that produces physicians capable of fully practicing in their specialty. Other testimony noted that full training of this nature is essential to protect women's health, especially in rural and underserved areas. Testimony also acknowledged that the resolution focuses solely on a training issue, and that any individual physician can choose not to perform a particular procedure based on a personal objection.

Amended language was proposed that would clarify that this type of compliance is monitored by the ACGME's Review Committee for Obstetrics and Gynecology, and the resolution's language should acknowledge this body's authority. ACGME Review Committees may also take into consideration recommendations made by the relevant specialty societies. Your Reference Committee agrees that the proposed amended language helps to elucidate the intent of this resolution, and further notes that the revised language reinforces the governing body's purview in this area.

Existing AMA policy is supportive of the wording of the revised language. H-295.923, "Medical Training and Termination of Pregnancy," notes that the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training. H-295.915, "Residency Program Responsibility," notes that the AMA affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession.

Therefore, your Reference Committee recommends that Resolution 957 be adopted as amended.

(27) RESOLUTION 958 – SEX AND GENDER BASED MEDICINE IN CLINICAL MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 958 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association collaborate with ~~ask 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 College Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to disseminate the work produced by ~~medical schools participating in the Accelerating Change in Medical Education~~ consortium and distribute pertinent information and a comprehensive ~~bibliography about the~~ assure the inclusion of ~~influence that~~ sex and gender have ~~upon clinical medicine~~ based medicine in medical education programs across ~~the spectrum of learners nationwide~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 958 be adopted as amended.

HOD ACTION: Resolution 958 adopted as amended.

Resolution 958 asks that our American Medical Association ask 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 assure the inclusion of sex and gender based medicine in medical education programs across the spectrum of learners nationwide.

Your Reference Committee heard testimony indicating that delegates are aware of the literature showing that potential bias may be inherent within medical trials, and that some trials (including drug studies) may be identified through disclosures that testing populations may have a skewed representation of specific gender and sexual traits. A number of medical schools that participated in the recent Accelerating Change in Medical Education (ACE) conference, held in Chicago in September 2017, presented work in these areas, and work being done in this regard should be disseminated to a broad and comprehensive audience of valued stakeholders in order to increase awareness of the scientific bias that some studies may have inherent in their research methods. At the same time, the AMA should be sensitive to the right of individual medical schools to determine their own curricular content. Substitute language was proposed that highlights the related work of the ACE consortium and proposes the dissemination of pertinent literature related to the concerns identified by the resolution.

Existing AMA policy is relevant to the intent of this resolution. AMA Policy H-525.976, “An Expanded Definition of Women’s Health,” states that our AMA recognizes the term “women’s health” as inclusive of all health conditions for which there is evidence that women’s risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.

Policy H-295.890 (1, 5, and 6), “Medical Education and Training in Women’s Health,” asks that our AMA encourage the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women’s health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women’s health throughout the basic science and clinical phases of the curriculum; encourage the development of a curriculum inventory and database in women’s health for use by medical schools and residency programs; encourage physicians to include continuing education in women’s health/gender based biology as part of their continuing professional development.

Therefore, your Reference Committee recommends that Resolution 958 be amended by addition and deletion.

(28) **RESOLUTION 959 – LIFESTYLE MEDICINE EDUCATION IN MEDICAL SCHOOL TRAINING AND PRACTICE**

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 959 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~explore pathways support policies and mechanisms legislation that incentivizes and/or provides funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate medical school education, graduate medical education and continuing medical education, including but not limited to education in nutrition, physical activity, behavior change, sleep health, tobacco cessation, alcohol use reduction, emotional wellness, and stress reduction.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 959 be adopted as amended.

HOD ACTION: Resolution 959 adopted as amended.

Resolution 959 asks that our American Medical Association support legislation that incentivizes and/or provides funding for the inclusion of lifestyle medicine education in medical school education, graduate medical education, and continuing medical education, including but not limited to education in nutrition, physical activity, behavior change, sleep health, tobacco cessation, alcohol use reduction, emotional wellness, and stress reduction.

Your Reference Committee heard mixed testimony on Resolution 959, reflecting concerns with legislative interference in medical education curricula. Other testimony was heard that the resolution, if adopted as policy, could have unintended consequences, including development of lifestyle medicine as its own separate specialty field of medicine. In addition, the laundry list of public health issues in the resolution was seen as problematic, in that it was not all-inclusive—and any attempt to make it so would be difficult, if not impossible. Your Reference Committee supports the edits provided by the Academic Physicians Section—which remove the reference to legislation from the resolution and incorporate the phrase “social determinants of health”—and allow our AMA to pursue a more measured and judicious approach to this complex issue. Therefore, your Reference Committee recommends adoption as amended.

(29) RESOLUTION 960 – MEDICAL STUDENT INVOLVEMENT AND VALIDATION OF THE STANDARDIZED VIDEO INTERVIEW IMPLEMENTATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 960 be amended by addition of a third Resolve to read as follows:

RESOLVED, That our AMA, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.
(Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 960 be adopted as amended.

HOD ACTION: Resolution 960 adopted as amended.

Resolution 960 asks that our AMA work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; and that the AMA advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges’ stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement.

Your Reference Committee heard extensive testimony on Resolution 960, an issue of critical concern to medical students, as reflected by its immediately forwarding from the Medical Student Section to the House of Delegates at this Interim Meeting. Multiple concerns were cited in testimony, including as of yet insufficient data supporting a wider rollout of the Standardized Video Interview (SVI) to all medical students (beyond the current pilot in emergency medicine); the potential for racial or ethnic biases; increased costs to students; and a possible digital divide between the technology cognoscenti and the have-nots. The concern that the Association of American

Medical Colleges could rapidly expand the SVI to all fields heightens the need for immediate action. Others, including the Council on Medical Education, urged for referral, to allow for sufficient time to review the SVI and its ramifications for residency applicants and programs alike. Your Reference Committee believes its proposed addition of a third Resolve, calling for our AMA to study this complex and deeply concerning issue, serves to meet the needs of both sides of the debate, with immediate action—through AMA policy and advocacy—as well as further review and rumination on the SVI. Therefore, your Reference Committee recommends adoption of Resolution 960 as amended.

(30) RESOLUTION 956 – HOUSE PHYSICIANS CATEGORY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 956
not be adopted.

HOD ACTION: Resolution 956 not adopted.

Resolution 956 asks that our American Medical Association work with state legislators and other regulatory organizations to develop the category of “House Physicians” to help address the anticipated physician need and shortfall of available practitioners in underserved areas of the United States.

Your Reference Committee heard strong opposition to Resolution 956. This resolution is not consistent with AMA policy, which opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited graduate medical education (GME) in the United States. It was also noted this could result in potential abuse of individuals working in this capacity, and would be of concern to state medical boards—to say nothing of the potential for patient safety concerns for a “subclass” of practitioners, and the subversion of physicians’ arguments against scope of practice incursions by nonphysicians. Further, some felt that the hospital employment requirement (if extended to other states) would not necessarily greatly improve the physician shortage problem and could be counterproductive to the AMA’s advocacy for additional GME slots. This resolution could also circumvent the requirements of passing the United States Medical Licensing Examination Step 3 as well as completing the required number of years of GME in the U.S.—all of which are requirements expected from U.S. medical graduates before practicing clinical medicine. Therefore, your Reference Committee recommends that Resolution 956 not be adopted.