Whereas, The lack of transparency of prices for medical services and drugs at point of service is a burden for both physicians and patients; and

Whereas, Prices for medical services vary greatly across the country; and

Whereas, Patients have the right to discuss with their physicians the benefits, risks, and costs of all treatment options; and

Whereas, Lack of transparency prevents physicians and patient from discussing expected costs for services and treatments and can potentially foster a sense of distrust between the patient and physician; and

Whereas, In specific states insurers can have gag clauses in contracts preventing disclosure of pricing information and claims data; and

Whereas, These arrangements affect hospital-based and other employed physician’s ability to develop rational prices, price transparency, appropriately discount, and use customary price discrimination for services; and

Whereas, There is the opportunity for the AMA to take the lead on state level bills targeting this issue; therefore be it

RESOLVED, 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

RESOLVED, That our AMA work with states and state medical societies to reduce health insurance contract provisions that prohibit the application of federal anti-kickback statute compliant discounts to the full charge list prices for services provided to patients who are uninsured or self-pay (Directive to Take Action); and be it further

Resolved, that our AMA support access to real-time prescription drug pricing and cost transparency at the point of prescribing. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/25/17

RELEVANT AMA POLICY

Price Transparency D-155.987
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.

Appropriate Hospital Charges H-155.958
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.

Physicians' Freedom to Establish Their Fees H-380.994
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.

Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16

Citation: (CMS Rep. 4, A-09)

Citation: (BOT Rep. JJ, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704 and Reaffirmation A-01; Reaffirmation A-09)
WHEREAS, The National Academy of Medicine (NAM) Initiative ‘Vital Directions for Health and Health Care’ makes an ‘Action Priority’ of the implementation of seamless digital interfaces for best care as one of action priorities; and

WHEREAS, The NAM Initiative includes the specific goals of making ‘necessary infrastructure and regulatory changes for clinical data accessibility and use’, ‘creating principles and standards for end-to-end interoperability’, and identifying ‘information technology and data strategies that support continuous learning’; and

WHEREAS, The value of the Prescription Drug Monitoring Program as a critical tool for patient safety is clear to those who utilize the system; and

WHEREAS, While this information has the potential to be misused, that risk was weighed against the benefit of having timely accurate information at the time of patient care and the result is a robust PDMP program; and

WHEREAS, Prescription data on controlled substances is only a small fraction of the medical information that could be used to improve patient safety, reduce unnecessary testing and better organize patient care; and

WHEREAS, A region-wide or state-wide system of secure medical record availability across provider groups has the potential to improve patient safety and is consistent with the NAM initiative; and

WHEREAS, Such systems have been in place for airplane and automobile care for decades; and

WHEREAS, For medical care in Oregon, seamless digital interfaces including the integration of the Prescription Drug Monitoring Program data should be available for the care of patients; therefore be it

RESOLVED, That our American Medical Association advocate for the interoperability of electronic medical data platforms for the purpose of improving patient care. (New HOD Policy)
Whereas, The CDC Advisory Committee on Immunization Practices (ACIP) has a well-established expert panel that follows scientifically rigorous and open processes to evaluate all aspects of vaccine safety and efficacy; and

Whereas, The unified immunization schedules established by the ACIP and its member organizations of the CDC, AAP and AFP have clarified the optimal immunization schedule; and

Whereas, Efforts to embrace discredited claims about vaccine safety may be validated by the creation of national commissions (such as a proposed commission on autism); and

Whereas, Comments by administration officials suggest that responsibility for immunization schedules may be moved from ACIP to the states; therefore be it

RESOLVED, That our American Medical Association support the rigorous scientific process of the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices and encourage education of parents and patients on the safety, risks, and benefits of vaccination (New HOD Policy); and be it further

RESOLVED, That our AMA support both national and state scientifically-based policies that promote the safety of vaccinations and effectively serve to increase the number of individuals vaccinated against communicable diseases. (New HOD Policy)

Fiscal Note: Not yet determined
REFERRAL CHANGES AND OTHER REVISIONS (A-17)

REFERRAL CHANGES

<table>
<thead>
<tr>
<th>WAS</th>
<th>IS NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Res. 004 - Policy on Quarantine</td>
<td>Res. 418 (Ref Comm D)</td>
</tr>
<tr>
<td>Res. 204 - Balance Billing State Regulation</td>
<td>Res. 127 (Ref Comm A)</td>
</tr>
</tbody>
</table>

REVISED REPORTS

- Board of Trustees Report 16 – Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere
- Board of Trustees Report 19 – CEJA and House of Delegates Collaboration

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- Resolution 402 - Destigmatizing Obesity (Obesity Medicine Association, Minority Affairs Section, Colorado, American Society for Metabolic and Bariatric Surgery, The Endocrine Society, American Association of Clinical Endocrinologists)
- Resolution 406 - Healthful Hospital Foods (District of Columbia, American College of Cardiology)
- Resolution 407 - SNAP Reform to Improve Health and Combat Food Deserts (District of Columbia, American College of Cardiology)
- Resolution 506 - Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder (Medical Student Section, American Society of Addiction Medicine)

* Additional sponsors underlined.
Madam Speaker, Members of the House of Delegates:

(1) LATE RESOLUTION(S)

The Committee on Rules and Credentials met Saturday, June 10, to discuss Late Resolution(s) 1001 – 1003. Sponsors of the late resolutions met with the committee to consider late resolutions, and were given the opportunity to present for the committee’s consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

• Late 1002 – Seamless Digital Interface for Best Care
• Late 1003 – Evidence-Based Vaccination Recommendations

Recommended not be accepted:

• Late 1001 – Barriers to Price Transparency

(2) REAFFIRMATION RESOLUTIONS

The Speakers asked the Committee on Rules and Credentials to review the recommendations for placing resolutions introduced at this meeting of the House of Delegates on the Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed remain active policies within the AMA policy database and therefore are part of the body of policy that can be used in setting the AMA’s agenda. It also resets the “sunset clock,” so such policies will remain viable for 10 years from the date of reaffirmation. The Committee recommends that current policy be reaffirmed in lieu of the following resolutions (current policy and AMA activities are listed in the Appendix to this report):

• 005 Perioperative Do No Resuscitate Orders
• 102 Establishing a Market System of Health System Financing and Delivery
• 103 Benefit Payment Schedule
• 104 Consultation Code Reinstatement
• 105 Opposition to Price Controls
• 113 The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services
• 122 Reimbursement for Pre-Colonoscopy Visit
• 202 Protect Individualized Compounding in Physicians’ Offices
• 215 Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act
• 221 AMA Policy on American Health Care Act
• 232 Create MACRA Opt-Out Option
• 234 Protections for Patients with Genetic Conditions
• 418 Policy on Quarantine
• 509 Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research
• 512 Advertising Restrictions and Limited Use of Dietary Supplements
Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Naiim S. Ali, MD; Robert C. Gibbs, MD; Cheryl Gibson Fountain, MD; John M. Montgomery, MD; David T. Walsworth, MD; and Cyndi J. Yag-Howard, MD; and on behalf of the committee those who appeared before the committee.

Naiim S. Ali, MD
Vermont

Robert C. Gibbs, MD *
Kansas

Cheryl Gibson Fountain, MD *
Michigan

John M. Montgomery, MD
Florida

David T. Walsworth, MD
Michigan

Cyndi J. Yag-Howard, MD
American Academy of Dermatology

Hugh Taylor, MD, Chair
American Academy of Family Physicians

* Alternate Delegate
• Resolution 005 Perioperative Do No Resuscitate Orders
  – E-5.4 Orders Not to Attempt Resuscitation (DNAR)

• Resolution 102 Establishing a Market System of Health System Financing and Delivery
  – H-373.998 Patient Information and Choice

• Resolution 103 Benefit Payment Schedule
  – H-385.987 Support for Indemnity Payment System

• Resolution 104 Consultation Code Reinstatement
  – D-70.953 Medicare’s Proposal to Eliminate Payments for Consultation Service Codes

• Resolution 105 Opposition to Price Controls
  – H-155.962 Maximum Allowable Cost of Prescription Medications
  – H-373.998 Patient Information and Choice

• Resolution 113 The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services
  – H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement
  – H-290.965 Affordable Care Act Medicaid Expansion
  – H-290.980 Status Report on the Medicaid Program
  ▪ In addition, AMA advocacy efforts consistently call for Medicare-level reimbursement rates in Medicaid to ensure access to care. In particular, the AMA submitted comments to the Centers for Medicare and Medicaid Services on the importance of ensuring adequate payment rates in the Medicaid program. The AMA also developed model legislation on Medicaid payment rates. This model bill, “Medicaid Primary Care Payment Parity Act,” establishes Medicaid payment rates for primary care services in parity with Medicare payment rates.

• Resolution 122 Reimbursement for Pre-Colonoscopy Visit
  – D-330.950 Support for Coverage of the Consultation by a Physician Prior to Screening Colonoscopy

• Resolution 202 Protect Individualized Compounding in Physicians' Offices
  – H-120.930 USP Compounding Rules
  ▪ In addition, AMA continues to advocate that in-office preparation for patient care is not compounding and constitute the practice of medicine consistent with AMA policy and this proposed resolution including:
    • AMA Letter to FDA Center for Drug Evaluation and Research (Aug. 26, 2016) (emphasizing that the FDA’s implementation of the Drug, Quality, and Security Act (DQSA) should not seek to regulate medical practice such as a physician’s in-office preparation of treatments for a patient).
    • AMA Letter to the United State Pharmacopeia (Jan. 29, 2016).
    • AMA meetings with FDA compound staff in May 2017 (discussing with FDA compounding staff the importance and need for in-office preparation).
APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

• Resolution 215  Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act
  – D-140.958 Medical Textbooks and Peer-Reviewed Journal Reprints per the Sunshine Act

• Resolution 221  AMA Policy on American Health Care Act
  – D-165.935 Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care
  – D-165.938 Redefining AMA’s Position on ACA and Healthcare Reform
    D-165.940 Monitoring the Affordable Care Act
  – H-165.835 AMA Advocacy for Health System Reform
  – H-165.828 Health Insurance Affordability
  – H-165.888 Evaluating Health System Reform Proposals
  – H-165.838 Health System Reform Legislation
    ▪ In addition, the goals of Resolution 221 have been met by numerous AMA reports examining and identifying what needs to be changed or improved with the ACA; by numerous reports summarizing AMA advocacy and Congressional actions on fixes or improvements to the ACA pursuant to D-165.938; and previous and ongoing AMA advocacy activities, as follows:
      • BOT Rep. 24-A-17, summarizing our AMA advocacy activities related to the AHCA (as of May 17, 2017)
      • CMS Report 5-I-13, Monitoring the Affordable Care Act
      • CMS Report 9-A-14, Improving the Affordable Care Act
      • AMA Vision on Health Reform
      • AMA Letter to Congress, January 3, 2017
      • AMA letter to the leadership of the House Energy and Commerce Committee and Ways and Means Committee, sharing views on the AHCA, March 7, 2017
      • AMA letter to House leadership on March 22, 2017, expressing opposition to the AHCA
      • AMA letter to Senate Finance Chairman Orrin Hatch, May 23, 2017

• Resolution 232  Create MACRA Opt-Out Option
  – H-390.838 MIPS and MACRA Exemption
    ▪ In addition, AMA has on-going advocacy to cover the language of Resolution 232 including:
      • AMA Comment Letter to CMS on MACRA Final Rule (urging CMS to provide additional exemptions for small groups to ensure the success of the MACRA program and encourage continued participation)
      • AMA Comment Letter to CMS on MACRA Proposed Rule (recommending lower reporting burdens and a broader exception for small group practices)
APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

• Resolution 234 Protections for Patients with Genetic Conditions
  – H-65.969 Genetic Discrimination and the Genetic Information Nondiscrimination Act
  – H-185.972 Genetic Information and Insurance Coverage
  – H-165.856 Health Insurance Market Regulation
  – H-170.963 Reward-Based Incentive Programs for Healthy Lifestyles
  – H-315.983 Patient Privacy and Confidentiality
  – D-185.981 Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act
  – H-65.965 Support of Human Rights and Freedom

• Resolution 418 Policy on Quarantine
  – E-8.4 Ethical Use of Quarantine & Isolation
  – H-440.835 AMA Role in Addressing Epidemics and Pandemics

• Resolution 509 Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research
  – H-480.943 Integration of Mobile Health Applications and Devices into Practice

• Resolution 512 Advertising Restrictions and Limited Use of Dietary Supplements
  – H-150.954 Dietary Supplements and Herbal Remedies

• Resolution 519 Liquid Medication Dosing
  – D-120.939 Promotion of Milliliter-Only for Liquid Medication Dosing

• Resolution 703 Certified Translation Services
  – D-385.978 Language Interpreters
  – D-160.992 Appropriate Reimbursement for Language Interpretive Services
  – H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship
  – H-385.929 Availability and Payment for Medical Interpreters Services in Medical Practices
  – H-155.976 Administrative Costs and Access to Health Care
    • In addition, the AMA developed a fact sheet on Section 1557 of the Affordable Care Act (available at https://www.ama-assn.org/sites/default/files/media-browser/public/ama-fact-sheet-section-1557.pdf). The fact sheet outlines who is subject to Section 1557, the requirements of Section 1557, and provides guidance and tips for physicians and practices on how to create a language access plan that is in compliance with Section 1557.
APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

• Resolution 704 Prior Authorization Abuse
  – H-320.950 Eliminating Precertification
  – H-320.945 Abuse of Preauthorization Procedures
  – H-155.976 Administrative Costs and Access to Health Care
  – D-190.974 Administrative Simplification in the Physician Practice
  – H-320.958 Emerging Trends in Utilization Management
  – H-320.968 Approaches to Increase Payer Accountability
    ▪ In addition, the AMA developed a set of 21 Prior Authorization and Utilization Management Reform Principles (available at https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf). These 21 Principles are intended to empower patients to play an active role in their care and assume a pivotal role in developing an individualized treatment plan to meet their health care needs; this care model can increase patients’ satisfaction with provided services and ultimately improve treatment quality and outcomes. There are five broad categories of principles including: clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and finally alternatives and exemptions.

• Resolution 710 Payment for Medicaid Interpreter Services
  – D-385.978 Language Interpreters
  – D-160.992 Appropriate Reimbursement for Language Interpretive Services
  – H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship
  – H-385.929 Availability and Payment for Medical Interpreters Services in Medical Practices
  – H-155.976 Administrative Costs and Access to Health Care
    ▪ In addition, the AMA developed a fact sheet on Section 1557 of the Affordable Care Act (available at https://www.ama-assn.org/sites/default/files/media-browser/public/ama-fact-sheet-section-1557.pdf). The fact sheet outlines who is subject to Section 1557, the requirements of Section 1557, and provides guidance and tips for physicians and practices on how to create a language access plan that is in compliance with Section 1557.
SUMMARY OF FISCAL NOTES (A-17)

**BOT Report(s)**
- 01 Annual Report: n/a
- 02 New Specialty Organizations Representation in the House of Delegates: Minimal
- 03 2016 Grants and Donations: Informational report
- 04 AMA 2018 Dues: Minimal
- 05 Update on Corporate Relationships: Informational report
- 06 Redefining AMA's Position on ACA and Healthcare Reform: Informational report
- 07 AMA Performance, Activities and Status in 2016: Informational report
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2016 Through February 2017: Informational report
- 09 Physician and Medical Staff Member Bill of Rights: Minimal
- 10 Creation of an AMA Fund for Physician Candidates: Minimal
- 11 Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging: Minimal
- 12 Unforeseen Consequences of Core Measures: Minimal
- 13 Closing Gaps in Prescription Drug Monitoring Programs: Minimal
- 14 Medicare Part B Double Dipping: Minimal
- 15 No Compromise on Anti-Female Genital Mutilation Policy: Minimal
- 16# Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere (REVISED): Minimal
- 17 Equality for Future Meetings Organized or Sponsored by the AMA: Minimal
- 18 Eliminate the Requirement of H&P Update: Minimal
- 19# CEJA and House of Delegates Collaboration (REVISED Page 3): Minimal
- 20 Study of Minimum Competencies and Scope of Medical Scribe Utilization: Within current budget
- 21 Risk Adjustment Refinement in Accountable Care Organization Settings and Medicare Shared Savings Programs: Informational report
- 23* Anti-Harassment Policy: Minimal
- 25# Specialty Society Representation in the House of Delegates - Five-Year Review: Minimal

**CC&B Report(s)**
- 01 Updated Bylaws - Emergency Business: Minimal
- 02 Specialty Society Allocation for House of Delegates Representation: Minimal

**CEJA Opinion(s)**
- 01 Collaborative Care: Informational report

**CEJA Report(s)**
- 01 Amendment to E-2.3.2, "Professionalism in Social Media": Minimal
- 02 Competence, Self-Assessment and Self-Awareness: Minimal
- 03 Ethical Physician Conduct in the Media: Minimal
- 04 CEJA's Sunset Review of 2007 House Policies: Minimal
- 05 Study Aid-in-Dying as End-of-Life Option: Informational report
- 06 Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient-Centered, Safe Care Services: Informational report
SUMMARY OF FISCAL NOTES (A-17)

CLRPD Report(s)
01 Delegate Allocation for Specialty Societies: Minimal
02 Demographic Characteristics of the House of Delegates and AMA Leadership: Informational report

CME Report(s)
01 Council on Medical Education Sunset Review of 2007 House of Delegates Policies: Minimal
02 Update on Maintenance of Certification and Osteopathic Continuous Certification: Modest
03 Obesity Education: Minimal
04 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages: Informational report
05 Options for Unmatched Medical Students: Informational report
06 Standardizing the Allopathic Residency Match System and Timeline: Minimal
07 Expansion of Public Service Loan Forgiveness: Modest
08 ACCME Proposed Changes in "Accreditation with Commendation" Continuing Medical Education Criteria Assessment Methodology: Informational report
09 Feasibility and Appropriateness of Transferring Jurisdiction Over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools: Minimal

CMS Report(s)
01 Council on Medical Service Sunset Review of 2007 AMA House Policies: Minimal
02 Health Care Financing Models: Informational report
03 Ensuring Continuity of Care Protections During Active Courses of Treatment: Modest
04 Survey of Addiction Treatment Centers’ Availability: Minimal
05 Hospital Consolidation: Minimal
06* Expansion of US Veterans’ Health Care Choices: Minimal
07 Retail Health Clinics: Minimal
08 Prior Authorization and Utilization Management Reform: Minimal
09 Capping Federal Medicaid Funding: Minimal
10 Physician-Focused Alternative Payment Models: Reducing Barriers: Modest

CSAPH Report(s)
01 CSAPH Sunset Review of 2007 Policies: Minimal
03 Strategies to Reduce the Consumption of Beverages with Added Sweeteners: Minimal
02 Emerging Drugs of Abuse are a Public Health Threat: Minimal

HOD Comm on Compensation of the Officers
* Report of the House of Delegates Committee on Compensation of the Officers: Estimated annual cost of $42,000 based on the three-year average of Internal Representation days.

Joint Report(s)
- CMS / CSAPH Report - Value of Preventive Services: Minimal

Report of the Speakers
01 Recommendations for Policy Reconciliation: informational report
## SUMMARY OF FISCAL NOTES (A-17)

### Resolution(s)

<table>
<thead>
<tr>
<th>Resolution</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Participation of Physicians on Healthcare Organization Boards: Minimal</td>
</tr>
<tr>
<td>002</td>
<td>Care of Women and Children in Family Immigration Detention: Minimal</td>
</tr>
<tr>
<td>003</td>
<td>Medical Spectrum of Gender: Modest</td>
</tr>
<tr>
<td>004</td>
<td>Moved to Reference Committee D (now Resolution 418): Minimal</td>
</tr>
<tr>
<td>005</td>
<td>Perioperative Do No Resuscitate Orders: Minimal</td>
</tr>
<tr>
<td>006</td>
<td>Increasing Access to Healthcare Insurance for Refugee Populations: Minimal</td>
</tr>
<tr>
<td>007</td>
<td>Healthcare as a Human Right: Minimal</td>
</tr>
<tr>
<td>008</td>
<td>Promoting the Use of Appropriate LGBTQIA Language in Medical Documentation: Minimal</td>
</tr>
<tr>
<td>009</td>
<td>Commercial Exploitation and Human Trafficking of Minors: Minimal</td>
</tr>
<tr>
<td>010</td>
<td>Access to Basic Human Services for Transgender Individuals: Modest</td>
</tr>
<tr>
<td>011</td>
<td>Revision of Researcher Certification and Institutional Review Board Protocols: Modest</td>
</tr>
<tr>
<td>012*</td>
<td>Promoting the AMA Model Medical Staff Code of Conduct and its Application to Employed Physicians: Modest</td>
</tr>
<tr>
<td>013*</td>
<td>Gender Identity Inclusion and Accountability in REMS: Modest</td>
</tr>
<tr>
<td>014*</td>
<td>The Need to Distinguish Between Physician Assisted Suicide and Aid in Dying: Modest</td>
</tr>
<tr>
<td>015*</td>
<td>Appropriate Placement of Transgender Prisoners: Minimal</td>
</tr>
<tr>
<td>016#</td>
<td>Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents: Modest</td>
</tr>
<tr>
<td>017#</td>
<td>Improving Medical Care in Immigrant Detention Centers: Minimal</td>
</tr>
<tr>
<td>018#</td>
<td>Patient and Physician Rights Regarding Immigration Status: Modest</td>
</tr>
<tr>
<td>019#</td>
<td>Who Owns Our Patients’ Data?: Modest</td>
</tr>
<tr>
<td>020#</td>
<td>Recognition of Physician Orders for Life Sustaining Treatment (POLST): Modest</td>
</tr>
<tr>
<td>0101</td>
<td>Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis: Minimal</td>
</tr>
<tr>
<td>0102</td>
<td>Establishing a Market System of Health System Financing and Delivery: Minimal</td>
</tr>
<tr>
<td>0103</td>
<td>Benefit Payment Schedule: Minimal</td>
</tr>
<tr>
<td>0104</td>
<td>Consultation Code Reinstatement: Modest</td>
</tr>
<tr>
<td>0105</td>
<td>Opposition to Price Controls: Minimal</td>
</tr>
<tr>
<td>0106</td>
<td>Medical Loss Ratio: Modest</td>
</tr>
<tr>
<td>0107</td>
<td>Repeal and Replace Our Outdated Refundable Advanceable Tax Credit Policy: Modest</td>
</tr>
<tr>
<td>0109</td>
<td>Simplify Medicare Face-to-Face Requirement: Minimal</td>
</tr>
<tr>
<td>0110</td>
<td>Over-the-Counter Contraceptive Drug Access: Modest</td>
</tr>
<tr>
<td>0111</td>
<td>VA Technology-Based Eye Care Services: Modest</td>
</tr>
<tr>
<td>0112</td>
<td>CMS Must Publish All Values for Non-Covered and Bundled Services: Modest</td>
</tr>
<tr>
<td>0113</td>
<td>The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services: Minimal</td>
</tr>
<tr>
<td>0114</td>
<td>Coverage for Preventive Care and Immunizations: Minimal</td>
</tr>
<tr>
<td>0115</td>
<td>Out-of-Network Care: Minimal</td>
</tr>
<tr>
<td>0116</td>
<td>Medicare Advantage Payment Policies: Minimal</td>
</tr>
<tr>
<td>0117</td>
<td>Expansion of U.S. Veterans’ Healthcare Choices: Modest</td>
</tr>
<tr>
<td>0118</td>
<td>Third Party Patient Reimbursement for Out-of-Network Physicians: Modest</td>
</tr>
<tr>
<td>0119</td>
<td>Support Efforts to Improve Access to Diabetes Self-Management Training Services: Modest</td>
</tr>
<tr>
<td>0120</td>
<td>National Pressure Ulcer Advisory Panel Recommendation for Pressure Ulcer Nomenclature Change: Minimal</td>
</tr>
</tbody>
</table>
SUMMARY OF FISCAL NOTES (A-17)

Resolution(s)

121  Advanced Care Planning Codes: Modest
122*  Reimbursement for Pre-Colonoscopy Visit: Modest
123*  Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases: Modest
124*  Emergency Medical Services Reimbursement for On-Site Treatment and Transport to Non-Traditional Destinations: Modest
125*  Medicaid Substance Use Disorder Coverage: Modest
126*  Insurance Coverage for Compression Stockings: Modest
127*  Balance Billing State Regulation: Modest
128#  Protecting Patients’ Access to Emergency Services: Modest
201  Improving Drug Affordability: Minimal
202  Protect Individualized Compounding in Physicians’ Offices: Modest
203  AMA to Support Pharmaceutical Pricing Negotiation in US: Minimal
204  Moved to Reference Committee A (now Resolution 127): Modest
205  Limiting Medicare Part D Enrollee Costs: Modest
206  MACRA and the Independent Practice of Medicine: Modest
207  Sky Rocketing Drug Prices: Modest
208  Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States: Minimal
209  Reduce Physician Practice Administrative Burden: Modest
210  Violation of HIPAA Electronic Transfer Standards by Insurer: Modest
211  Sale of Health Insurance Across State Lines: Modest
212  Advocacy for Seamless Interface between Physician Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) to be Created and Financed by the Commercial EHR and Dispensing Program Providers: Modest
213  Copying and/or Scanning Costs: Modest
214  Medical Liability Coverage Through the Federal Tort Claims Act: Modest
215  Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act: Modest
216  Electronically Prescribed Controlled Substances Without Added Processes: Modest
217  Inappropriate Requests for DEA Numbers: Modest
218  Licensing of Electronic Health Records: Modest
219  Integration of Drug Price Information into Electronic Medical Records: Modest
220  Accountability of 911 Emergency Services Funding: Modest
221  AMA Policy on American Health Care Act: Modest
222  Response to Burdensome Governmental Mandate: Modest
223  Tax Deductions for Direct-to-Consumer Advertising: Minimal
224  Medicare Prepayment and RAC Audit Reform: Modest
225  Truth in Advertising: Minimal
226  Ask CMS and HHS to Remove Practice Expense and Malpractice Expense from Publicly Reported Payments: Modest
227  Improving Clinical Utility of Medical Documentation: Modest
228  Free Speech Applies to Scientific Knowledge: Modest
229*  Medicare's Appropriate Use Criteria Program: Modest
230*  CMS Reimbursement Guidelines for Teaching Physician Supervision: Modest
231*  Naloxone Price Increase: Minimal
SUMMARY OF FISCAL NOTES (A-17)

Resolution(s)

232* Create MACRA Opt-Out Option: Modest
233* Regulation of Physician Assistants: Modest
234* Protections for Patients with Genetic Conditions: Modest
235* Towards Eliminating ERISA State Preemption of Health Plan Liability: Modest
236* Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising: Modest
237* Protection of Clinician-Patient Privilege: Modest
238* Limitation on Reports to the National Practitioner Data Bank Unrelated to Patient Care: Modest
239* AMA Support for Texting as Approved HIPAA Communication: Modest
240* Minimum Federal Standards for Interstate Sale of Health Insurance: Modest
241# Timeliness in Obtaining Medical Records from Other Providers: Modest
242# Legislation to Require Timely Action on Prior Authorization: Modest
301 Mental Health Disclosures on Physician Licensing Applications: Minimal
302 Comprehensive Review of CME Process: Modest
303 Addressing Medical Student Mental Health Through Data Collection and Screening: Minimal
304 Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding: Minimal
305 Reduction of Caregiver Burnout: Estimated cost between $15,000 - $25,000 (professional fees) depending on the type of multimedia module created.
306 US International Medical Graduates in Physician Workforce: Modest
307 Formal Business and Practice Management Training During Medical Education: Minimal
308 Immigration Reform Impacts on International Medical Graduate Training and Patient Access: Modest
309 Future of the USMLE: Examining Multi-Step Structure and Score Usage: Modest
310 Breast Pump Accommodations During Medical Licensing Exams: Minimal
311 Support of International Medical Students and Graduates: Minimal
312 Supporting International Medical Graduates and Students: Minimal
313 Study of Declining Native American Medical Student Enrollment: Modest
314 Educating a Diverse Physician Workforce: Estimated cost between $15K - $20K for professional fees to develop online materials to address cultural, racial and religious issues in patient care.
315 Inclusion of Developmental Disabilities Curriculum in Undergraduate, Graduate and Continuing Medical Education of Physicians: Minimal
316 Action Steps Regarding Maintenance of Certification: Moderate
317* Immigration: Modest
318* Oppose Direct-to-Consumer Advertising of the ABMS MOC Product: Modest
319* Public Access to Initial Board Certification Status of Time Limited ABMS Diplomates: Minimal
320* Cultural Competence in Standardized Patient Programs Within Medical Education: Minimal
321* Continued Support of H-1B Visa Programs for International Medical Graduates: Modest
322* Ending Maintenance of Certification Examinations: Minimal
323* Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved / Economically Depressed Areas: Modest
324# Improve HRSA Projections of the Physician Workforce: Modest
325# Ensure an Effective H-1B Visa Program to Protect Patient Access to Care: Modest
326# Supporting International Medical Graduates and Students: Minimal
401 Use of Phrase "Gun Violence Mitigation" in Lieu of "Gun Control": Minimal
402 Destigmatizing Obesity: Modest
SUMMARY OF FISCAL NOTES (A-17)

Resolution(s)
403 Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking: Modest
404 Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons: Minimal
405 Decreasing Screen Time and Increasing Outdoor Activity to Offset Myopia Onset and Progression in School Children: Minimal
406 Healthful Hospital Foods: Minimal
407 SNAP Reform to Improve Health and Combat Food Deserts: Modest
408 Increased Oversight of Suicide Prevention Training for Correctional Facility Staff: Minimal
409 Pediatric/Adolescent Informed Consent Concussion Discussion: Minimal
410 Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals: Minimal
411 Preserving Vaccine Policy in the United States: Minimal
412 Domestic Water Testing for Lead Toxic Kids: Modest
413 Ocular Burns from Liquid Laundry Packets: Modest
414 Imposing Taxes on Sugar-Sweetened Beverages: Modest
415* Food Bank and Pantry Distribution of Nutrient-Dense Foods: Modest
416* Policy and Economic Support for Early Child Care: Modest
417* Mandatory Public Health Reporting of Law Enforcement Related Injuries and Death: Minimal
418# Policy on Quarantine: Minimal
419# Improving Physicians’ Ability to Discuss Firearm Safety: Estimated cost of $25,000 to implement resolution
501 Airplane Emissions: Modest
502 Access to Cosmetic Product Ingredients: Modest
503 Women and Mental Health: Modest
504 Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women: Modest
505 Recognition of Sepsis in the Community: Minimal
506 Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder: Modest
507 Educating Physicians and Young Adults on Synthetic Drugs: Minimal
508 Support for Service Animals, Emotional Support Animals, Animals in Healthcare and Medical Benefits of Pet Ownership: Minimal
509 Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research: Estimated cost of $200,000 reflects the cost of hiring an outside firm to study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research.
510 Ban on the Use of Paraquat: Modest
511 Future of Pain Care: Estimated cost of $75,000 to convene stakeholder task force, make recommendations for educating healthcare providers on treatment of patients with pain, and discuss strategies to mitigate acute pain, educate about them and suggest research studies into them.
512 Advertising Restrictions and Limited Use of Dietary Supplements: Modest
513 Supervised Injection Facilities: Estimated cost of $47,000 (staff costs, professional fees, and travel and meetings) to conduct a comprehensive study of Supervised Injection Facilities in the United States.
514 Retinoblastoma Due to Pre-Natal Residential Pesticide Exposure: Minimal
515 Safe Use, Storage and Disposal of Leftover Opioids and Other Controlled Substances: Modest
516 In-Flight Emergencies: Modest
517 Choline Supplementation in Prenatal Vitamins: Modest
518 Recognition of Infertility as a Disease: Modest
519* Liquid Medication Dosing: Modest
520* Combination Clotrimazole/Betamethasone Diproprionate Cream Warning: Modest
521* Retail Prescription Bottle Label Privacy: Modest
SUMMARY OF FISCAL NOTES (A-17)

Resolution(s)

522# National Coordinated Strategy for Sepsis: Modest
523# AMA Support for Evidence-Based Environmental Statutes and Regulations: Modest
524# Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis: Modest
525# Providing for Prescription Drug Donation: Modest
526# NIH Funding for Basic and Translational Pain Research: Modest

526# Reinstall the AMA Commission to End Health Care Disparities: Estimated annual cost of $50,000 for two yearly meetings.

528# Studying Healthcare Institutions that Provide Child Care Services: Estimated cost at least $200,000 includes help from an outside vendor. The cost will likely increase as more parameters are established.

529# Sexual Orientation and Gender Identity Demographic Collection by the AMA: Moderate
530# High Cost to Authors for Open Source Peer Reviewed Publications: Minimal
531# Pronunciation of Pharmaceutical Names: Minimal
532* Add Patients to the AMA Mission Statement: Minimal

535# AMA to Protect Human Health from the Effects of Climate Change by Ending Its Investments in Fossil Fuel Companies (Divestment): The potential adverse impact on the AMA's financial returns cannot be determined with precision at this time

537# Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine: Modest
538# Model Hospital Medical Staff Bylaws: Estimated cost of approximately $100,000 up front cost, plus $36,000 per year to maintain

541# Third Party Payers Mandating Doctor and Patient Transfers of Prescriptions: Minimal
542# Credentials / Specialty Added to Clinical Note Signatures: Modest
543# Certified Translation Services: Modest
544# Prior Authorization Abuse: Modest
545# Regulating Health Plans Medical Advice: Modest
546# Concurrent and Overlapping Surgery: Modest
547# Inclusion of Continuing Care Retirement Centers & Long-Term Care Facilities in Accountable Care Organizations Investment Model: Modest

548# Removing ‘Three Star Minimum’ Requirement for Skilled Nursing Facilities to Participate in Next Gen Accountable Care Organizations & Bundled Payments for Care Improvement Programs and Care for Patients with Waiver of Three Night Hospital Stay Requirement: Modest
549# Management of Physician and Medical Student Stress: Minimal
550# Payment for Medicaid Interpreter Services: Minimal
551# Expanding Access to Screening Tools for Social Determinants of Health: Estimated cost of $35,000 to create and support evidence-based screening tools.

552* Pay-for-Performance Incentives: Minimal
553* Urge AMA to Release a White Paper on ACOs: Modest
554* Timely Referral to Pain Management Specialist: Modest
555* Prescription Availability for Weekend Discharges: Modest
556* Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records: Minimal

557* Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit: Modest
558# Developing Physician Leadership in the Implementation of Diagnostic Error Surveillance: Modest
559# System Approach to Medical Staff Governance: Modest
560# Medical Staff Non-Punitive Reporting Processes: Modest
561# Secret Ballots in Medical Staff Voting Processes: Modest
SUMMARY OF FISCAL NOTES (A-17)

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000

* Contained in Handbook Addendum
The Board of Trustees is pleased to nominate Boris D. Lushniak, MD, College Park, Maryland, for the 2017 Distinguished Service Award.

Dr. Lushniak has served our profession for over 27 years through his many roles in the Public Health Service including disaster responses in Bangladesh, St. Croix, Russia and Kosovo. He was a member of the CDC/NIOSH team at Ground Zero in 2001, and was on the team investigating the anthrax attacks in Washington. In Monrovia, Liberia, Dr. Lushniak commanded the medical unit at the only US government hospital providing care to Ebola patients.

Dr. Lushniak served as Deputy Surgeon General beginning in 2010, and as Acting Surgeon General from 2013-2014. During his tenure he released *The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General, 2014* and the first ever *Surgeon General’s Call to Action to Prevent Skin Cancer*.

The Distinguished Service Award may be made to a member of the Association for meritorious service in the science and art of medicine, and your Board of Trustees believes Dr. Lushniak merits the recognition provided by this award.
1. Report of the Committee on Rules and Credentials - Hugh Taylor, MD, Chair

2. Presentation, Correction and Adoption of Minutes of 2016 Interim Meeting

3. Remarks of the Speaker - Susan R. Bailey, MD

4. Announcement of Changes in Reference Committees

5. Report(s) of the Board of Trustees - Patrice A. Harris, MD, Chair
   01 Annual Report (F)
   02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
   03 2016 Grants and Donations (Info. Report)
   04 AMA 2018 Dues (F)
   05 Update on Corporate Relationships (Info. Report)
   06 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
   07 AMA Performance, Activities and Status in 2016 (Info. Report)
   08 Annual Update on Activities and Progress in Tobacco Control: March 2016 Through February 2017 (Info. Report)
   09 Physician and Medical Staff Member Bill of Rights (G)
   10 Creation of an AMA Fund for Physician Candidates (F)
   11 Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging (B)
   12 Unforeseen Consequences of Core Measures (G)
   13 Closing Gaps in Prescription Drug Monitoring Programs (B)
   14 Medicare Part B Double Dipping (B)
   15 No Compromise on Anti-Female Genital Mutilation Policy (Amendments to C&B)
   16# Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere (REVISED) (F)
   17 Equality for Future Meetings Organized or Sponsored by the AMA (F)
   18 Eliminate the Requirement of H&P Update (G)
   19# CEJA and House of Delegates Collaboration (REVISED Page 3) (Amendments to C&B)
   20 Study of Minimum Competencies and Scope of Medical Scribe Utilization (G)
   21 Risk Adjustment Refinement in Accountable Care Organization Settings and Medicare Shared Savings Programs (Info. Report)
   22 Council on Legislation Sunset Review of 2007 House Policies (B)
   23* Anti-Harassment Policy (F)
   25# Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)

6. Report(s) of the Council on Constitution and Bylaws - Colette R. Willins, MD, Chair
   01 Updated Bylaws - Emergency Business (Amendments to C&B)
   02 Specialty Society Allocation for House of Delegates Representation (Amendments to C&B)
7. Report(s) of the Council on Ethical and Judicial Affairs - Ronald J. Clearfield, MD, Chair
   01 Amendment to E-2.3.2, "Professionalism in Social Media" (Amendments to C&B)
   02 Competence, Self-Assessment and Self-Awareness (Amendments to C&B)
   03 Ethical Physician Conduct in the Media (Amendments to C&B)
   04 CEJA's Sunset Review of 2007 House Policies (Amendments to C&B)
   05 Study Aid-in-Dying as End-of-Life Option (Info. Report)
   06 Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient-Centered, Safe Care Services (Info. Report)

8. Opinion(s) of the Council on Ethical and Judicial Affairs - Ronald J. Clearfield, MD, Chair
   01 Collaborative Care (Info. Report)

9. Report(s) of the Council on Long Range Planning and Development - Mary T. Herald, MD, Chair
   01 Delegate Allocation for Specialty Societies (Amendments to C&B)
   02 Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)

10. Report(s) of the Council on Medical Education - Patricia L. Turner, MD, Chair
    01 Council on Medical Education Sunset Review of 2007 House of Delegates Policies (C)
    02 Update on Maintenance of Certification and Osteopathic Continuous Certification (C)
    03 Obesity Education (C)
    04 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages (Info. Report)
    05 Options for Unmatched Medical Students (Info. Report)
    06 Standardizing the Allopathic Residency Match System and Timeline (C)
    07 Expansion of Public Service Loan Forgiveness (C)
    08 ACCME Proposed Changes in "Accreditation with Commendation" Continuing Medical Education Criteria Assessment Methodology (Info. Report)
    09 Feasibility and Appropriateness of Transferring Jurisdiction Over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools (C)

11. Report(s) of the Council on Medical Service - Peter S. Lund, MD, Chair
    01 Council on Medical Service Sunset Review of 2007 AMA House Policies (A)
    02 Health Care Financing Models (Info. Report)
    03 Ensuring Continuity of Care Protections During Active Courses of Treatment (A)
    04 Survey of Addiction Treatment Centers' Availability (G)
    05 Hospital Consolidation (G)
    06* Expansion of US Veterans' Health Care Choices (A)
    07 Retail Health Clinics (G)
    08 Prior Authorization and Utilization Management Reform (G)
    09 Capping Federal Medicaid Funding (A)
    10 Physician-Focused Alternative Payment Models: Reducing Barriers (G)

12. Report(s) of the Council on Science and Public Health - S. Bobby Mukkamala, MD, Chair
    01 CSAPH Sunset Review of 2007 Policies (E)
    02 Emerging Drugs of Abuse are a Public Health Threat (E)
    03 Strategies to Reduce the Consumption of Beverages with Added Sweeteners (D)
13. Report(s) of the HOD Committee on Compensation of the Officers - Anthony Padula, MD, Chair
   * Report of the House of Delegates Committee on Compensation of the Officers (F)

14. Joint Report(s)
   - CMS / CSAPH Report - Value of Preventive Services (A)

15. Report(s) of the Speakers - Susan R. Bailey, MD, Speaker; Bruce A. Scott, MD, Vice Speaker
   01 Recommendations for Policy Reconciliation (Info. Report)

--EXTRACTION OF INFORMATIONAL REPORTS--

16. Unfinished business

17. New Business (Introduction of Resolutions)
   001 Participation of Physicians on Healthcare Organization Boards (Amendments to C&B)
   002 Care of Women and Children in Family Immigration Detention (Amendments to C&B)
   003 Medical Spectrum of Gender (Amendments to C&B)
   004 Moved to Reference Committee D (now Resolution 418) (Amendments to C&B)
   005 Perioperative Do No Resuscitate Orders (Amendments to C&B)
   006 Increasing Access to Healthcare Insurance for Refugee Populations (Amendments to C&B)
   007 Healthcare as a Human Right (Amendments to C&B)
   008 Promoting the Use of Appropriate LGBTQIA Language in Medical Documentation (Amendments to C&B)
   009 Commercial Exploitation and Human Trafficking of Minors (Amendments to C&B)
   010 Access to Basic Human Services for Transgender Individuals (Amendments to C&B)
   011 Revision of Researcher Certification and Institutional Review Board Protocols (Amendments to C&B)
   012* Promoting the AMA Model Medical Staff Code of Conduct and its Application to Employed Physicians (Amendments to C&B)
   013* Gender Identity Inclusion and Accountability in REMS (Amendments to C&B)
   014* The Need to Distinguish Between Physician Assisted Suicide and Aid in Dying (Amendments to C&B)
   015* Appropriate Placement of Transgender Prisoners (Amendments to C&B)
   016# Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents (Amendments to C&B)
   017# Improving Medical Care in Immigrant Detention Centers (Amendments to C&B)
   018# Patient and Physician Rights Regarding Immigration Status (Amendments to C&B)
   019# Who Owns Our Patients’ Data? (Amendments to C&B)
   020# Recognition of Physician Orders for Life Sustaining Treatment (POLST) (Amendments to C&B)
   101 Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis (A)
   102 Establishing a Market System of Health System Financing and Delivery (A)
   103 Benefit Payment Schedule (A)
   104 Consultation Code Reinstatement (A)
   105 Opposition to Price Controls (A)
   106 Medical Loss Ratio (A)
   107 Repeal and Replace Our Outdated Refundable Advanceable Tax Credit Policy (A)
108 Out-of-Network Insurance Benefit Availability in Individual Insurance Market and Self-Funded Plans (A)
109 Simplify Medicare Face-to-Face Requirement (A)
110 Over-the-Counter Contraceptive Drug Access (A)
111 VA Technology-Based Eye Care Services (A)
112 CMS Must Publish All Values for Non-Covered and Bundled Services (A)
113 The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services (A)
114 Coverage for Preventive Care and Immunizations (A)
115 Out-of-Network Care (A)
116 Medicare Advantage Payment Policies (A)
117 Expansion of U.S. Veterans' Healthcare Choices (A)
118 Third Party Patient Reimbursement for Out-of-Network Physicians (A)
119 Support Efforts to Improve Access to Diabetes Self-Management Training Services (A)
120 National Pressure Ulcer Advisory Panel Recommendation for Pressure Ulcer Nomenclature Change (A)
121 Advanced Care Planning Codes (A)
122* Reimbursement for Pre-Colonoscopy Visit (A)
123* Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases (A)
124* Emergency Medical Services Reimbursement for On-Site Treatment and Transport to Non-Traditional Destinations (A)
125* Medicaid Substance Use Disorder Coverage (A)
126* Insurance Coverage for Compression Stockings (A)
127* Balance Billing State Regulation (A)
128# Protecting Patients' Access to Emergency Services (A)
201 Improving Drug Affordability (B)
202 Protect Individualized Compounding in Physicians' Offices (B)
203 AMA to Support Pharmaceutical Pricing Negotiation in US (B)
204 Moved to Reference Committee A (now Resolution 127) (B)
205 Limiting Medicare Part D Enrollee Costs (B)
206 MACRA and the Independent Practice of Medicine (B)
207 Sky Rocketing Drug Prices (B)
208 Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States (B)
209 Reduce Physician Practice Administrative Burden (B)
210 Violation of HIPAA Electronic Transfer Standards by Insurer (B)
211 Sale of Health Insurance Across State Lines (B)
212 Advocacy for Seamless Interface between Physician Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) to be Created and Financed by the Commercial EHR and Dispensing Program Providers (B)
213 Copying and/or Scanning Costs (B)
214 Medical Liability Coverage Through the Federal Tort Claims Act (B)
215 Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act (B)
216 Electronically Prescribed Controlled Substances Without Added Processes (B)
217 Inappropriate Requests for DEA Numbers (B)
218 Licensing of Electronic Health Records (B)
219  Integration of Drug Price Information into Electronic Medical Records (B)
220  Accountability of 911 Emergency Services Funding (B)
221  AMA Policy on American Health Care Act (B)
222  Response to Burdensome Governmental Mandate (B)
223  Tax Deductions for Direct-to-Consumer Advertising (B)
224  Medicare Prepayment and RAC Audit Reform (B)
225  Truth in Advertising (B)
226  Ask CMS and HHS to Remove Practice Expense and Malpractice Expense from Publicly Reported Payments (B)
227  Improving Clinical Utility of Medical Documentation (B)
228  Free Speech Applies to Scientific Knowledge (B)
229*  Medicare's Appropriate Use Criteria Program (B)
230*  CMS Reimbursement Guidelines for Teaching Physician Supervision (B)
231*  Naloxone Price Increase (B)
232*  Create MACRA Opt-Out Option (B)
233*  Regulation of Physician Assistants (B)
234*  Protections for Patients with Genetic Conditions (B)
235*  Towards Eliminating ERISA State Preemption of Health Plan Liability (B)
236*  Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising (B)
237*  Protection of Clinician-Patient Privilege (B)
238*  Limitation on Reports to the National Practitioner Data Bank Unrelated to Patient Care (B)
239*  AMA Support for Texting as Approved HIPAA Communication (B)
240*  Minimum Federal Standards for Interstate Sale of Health Insurance (B)
241#  Timeliness in Obtaining Medical Records from Other Providers (B)
242#  Legislation to Require Timely Action on Prior Authorization (B)
301  Mental Health Disclosures on Physician Licensing Applications (C)
302  Comprehensive Review of CME Process (C)
303  Addressing Medical Student Mental Health Through Data Collection and Screening (C)
304  Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding (C)
305  Reduction of Caregiver Burnout (C)
306  US International Medical Graduates in Physician Workforce (C)
307  Formal Business and Practice Management Training During Medical Education (C)
308  Immigration Reform Impacts on International Medical Graduate Training and Patient Access (C)
309  Future of the USMLE: Examining Multi-Step Structure and Score Usage (C)
310  Breast Pump Accommodations During Medical Licensing Exams (C)
311  Support of International Medical Students and Graduates (C)
312  Supporting International Medical Graduates and Students (C)
313  Study of Declining Native American Medical Student Enrollment (C)
314  Educating a Diverse Physician Workforce (C)
315  Inclusion of Developmental Disabilities Curriculum in Undergraduate, Graduate and Continuing Medical Education of Physicians (C)
316  Action Steps Regarding Maintenance of Certification (C)
317*  Immigration (C)
318*  Oppose Direct-to-Consumer Advertising of the ABMS MOC Product (C)
319* Public Access to Initial Board Certification Status of Time Limited ABMS Diplomates (C)
320* Cultural Competence in Standardized Patient Programs Within Medical Education (C)
321* Continued Support of H-1B Visa Programs for International Medical Graduates (C)
322* Ending Maintenance of Certification Examinations (C)
323* Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved / Economically Depressed Areas (C)
324# Improve HRSA Projections of the Physician Workforce (C)
325# Ensure an Effective H-1B Visa Program to Protect Patient Access to Care (C)
326# Supporting International Medical Graduates and Students (C)
401 Use of Phrase "Gun Violence Mitigation" in Lieu of "Gun Control" (D)
402 Destigmatizing Obesity (D)
403 Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking (D)
404 Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons (D)
405 Decreasing Screen Time and Increasing Outdoor Activity to Offset Myopia Onset and Progression in School Children (D)
406 Healthful Hospital Foods (D)
407 SNAP Reform to Improve Health and Combat Food Deserts (D)
408 Increased Oversight of Suicide Prevention Training for Correctional Facility Staff (D)
409 Pediatric/Adolescent Informed Consent Concussion Discussion (D)
410 Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals (D)
411 Preserving Vaccine Policy in the United States (D)
412 Domestic Water Testing for Lead Toxic Kids (D)
413 Ocular Burns from Liquid Laundry Packets (D)
414 Imposing Taxes on Sugar-Sweetened Beverages (D)
415* Food Bank and Pantry Distribution of Nutrient-Dense Foods (D)
416* Policy and Economic Support for Early Child Care (D)
417* Mandatory Public Health Reporting of Law Enforcement Related Injuries and Death (D)
418# Policy on Quarantine (D)
419# Improving Physicians' Ability to Discuss Firearm Safety (D)
501 Airplane Emissions (E)
502 Access to Cosmetic Product Ingredients (E)
503 Women and Mental Health (E)
504 Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women (E)
505 Recognition of Sepsis in the Community (E)
506 Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder (E)
507 Educating Physicians and Young Adults on Synthetic Drugs (E)
508 Support for Service Animals, Emotional Support Animals, Animals in Healthcare and Medical Benefits of Pet Ownership (E)
509 Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research (E)
510 Ban on the Use of Paraquat (E)
511 Future of Pain Care (E)
512 Advertising Restrictions and Limited Use of Dietary Supplements (E)
513 Supervised Injection Facilities (E)
717* Allowing Exceptions to the Centers for Medicare & Medicaid Services' Locum Tenens 60-Day Limit (G)
718# Developing Physician Leadership in the Implementation of Diagnostic Error Surveillance (G)
719# System Approach to Medical Staff Governance (G)
720# Medical Staff Non-Punitive Reporting Processes (G)
721# Secret Ballots in Medical Staff Voting Processes (G)

18. Report of the Committee on Rules and Credentials - Hugh Taylor, MD, Chair

* contained in the Handbook Addendum
# contained in the Sunday Tote
ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (A-17)
Michael B. Hoover, MD, Chair

June 10, 2017
Regency C
Hyatt Regency Chicago
Chicago

1. Board of Trustees Report 02 – New Specialty Organizations Representation in the House of Delegates
2. Board of Trustees Report 15 – No Compromise on Anti-Female Genital Mutilation Policy
3. Board of Trustees Report 19 – CEJA and House of Delegates Collaboration
8. Council on Ethical and Judicial Affairs Report 01 – Amendment to E-2.3.2, “Professionalism in Social Media”
9. Council on Ethical and Judicial Affairs Report 02 – Competence, Self-Assessment and Self-Awareness
10. Council on Ethical and Judicial Affairs Report 03 – Ethical Physician Conduct in the Media
12. Resolution 001 – Participation of Physicians on Healthcare Organization Boards
13. Resolution 002 – Care of Women and Children in Family Immigration Detention
14. Resolution 017 – Improving Medical Care in Immigrant Detention Centers
17. Resolution 019 – Who Owns Our Patients' Data?
18. Resolution 018 – Patient and Physician Rights Regarding Immigration Status
19. Resolution 005 – Perioperative Do Not Resuscitate Orders
20. Resolution 003 – Medical Spectrum of Gender
21. Resolution 008 – Promoting the Use of Appropriate LGBTQIA Language in Medical Documentation
22. Resolution 010 – Access to Basic Human Services for Transgender Individuals
23. Resolution 015 – Appropriate Placement of Transgender Prisoners
24. Resolution 013 – Gender Identity Inclusion and Accountability in REMS

Note: Items in italics were originally placed on the reaffirmation consent calendar, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
25. Resolution 009 – Commercial Exploitation and Human Trafficking of Minors
26. Resolution 007 – Healthcare as a Human Right
28. Resolution 012 – Promoting the AMA Model Medical Staff Code of Conduct and its Application to Employed Physicians
29. Resolution 020 – Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms
30. Resolution 014 – The Need to Distinguish Between Physician Assisted Suicide and Aid in Dying

Note: Items in italics were originally placed on the reaffirmation consent calendar, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
ORDER OF BUSINESS

Reference Committee A (A-17)
John H. Armstrong, MD, Chair

June 11, 2017
Regency Ballroom A
Hyatt Regency Chicago
Chicago

3. Council on Medical Service Report 3 - Ensuring Continuity of Care Protections during Active Courses of Treatment
   Resolution 115 - Out-of-Network Care
   Resolution 118 - Third Party Patient Reimbursement for Out-of-Network Physicians
   Resolution 127 - Balance Billing State Regulation
5. Resolution 128 - Protecting Patients’ Access to Emergency Services
   Resolution 117 - Expansion of U.S. Veterans’ Healthcare Choices
7. Resolution 111 - VA Technology-Based Eye Care Services
9. Resolution 113 - The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services
10. Resolution 125 - Medicaid Substance Use Disorder Coverage
11. Resolution 107 - Repeal and Replace Our Outdated Refundable Advanceable Tax Credit Policy
12. Resolution 102 - Establishing a Market System of Health System Financing and Delivery

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
13. Resolution 103 - Benefit Payment Schedule
14. Resolution 105 - Opposition to Price Controls
15. Resolution 106 - Medical Loss Ratio
16. Resolution 110 - Over-the-Counter Contraceptive Drug Access
17. Resolution 114 - Coverage for Preventive Care and Immunizations
18. Resolution 119 - Support Efforts to Improve Access to Diabetes Self-Management Training Services
19. Resolution 123 - Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases
20. Resolution 122 - Reimbursement for the Pre-Colonoscopy Visit
21. Resolution 104 - Consultation Code Reinstatement
22. Resolution 109 - Simplify Medicare Face to Face Requirement
23. Resolution 112 - CMS Must Publish All Values for Non-Covered and Bundled Services
25. Resolution 120 - National Pressure Ulcer Advisory Panel Recommendation for Pressure Ulcer Nomenclature Change
26. Resolution 121 - Advanced Care Planning Codes
27. Resolution 124 - Emergency Medical Services Reimbursement for On-Site Treatment and Transport to Non-Traditional Destinations
28. Resolution 101 - Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis
29. Resolution 126 - Insurance Coverage for Compression Stockings

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
ORDER OF BUSINESS

Reference Committee B (A-17)
Alethia Morgan, MD, Chair

June 11, 2017
Regency Ballroom B

1. Board of Trustees Report 11 - Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging
   Resolution 239 - AMA Support for Texting as Approved HIPAA Communication
   Resolution 212 - Advocacy for Seamless Interface between Physician Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs to be Created and Financed by the Commercial EHR and Dispensing Program Providers
3. Board of Trustees Report 14 - Medicare Part B Double Dipping
5. Resolution 201 - Improving Drug Affordability
7. Resolution 205 - Limiting Medicare Part D Enrollee Costs
8. Resolution 207 - Skyrocketing Drug Prices
9. Resolution 231 - Naloxone Price Increase
10. Resolution 202 - Protect Individualized Compounding in Physicians’ Offices
11. Resolution 206 - MACRA and the Independent Practice of Medicine
    Resolution 209 - Reduce Physician Practice Administrative Burden
    Resolution 222 - Response to Burdensome Governmental Mandate
12. Resolution 232 - Create MACRA Opt-Out Option
13. Resolution 208 - Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States
14. Resolution 210 - Violation of HIPAA Electronic Transaction Standards by Insurer
15. Resolution 211 - Sale of Health Insurance Across State Lines
    Resolution 240 - Minimum Federal Standards for Interstate Sale of Health Insurance
16. Resolution 213 - Copying and/or Scanning Costs
17. Resolution 214 - Medical Liability Coverage Through the Federal Tort Claims Act
18. Resolution 215 - Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act
19. Resolution 216 - Electronically Prescribe Controlled Substances Without Added Processes
20. Resolution 217 - Inappropriate Requests for DEA Numbers
21. Resolution 218 - Licensing of Electronic Health Records
22. Resolution 219 - Integration of Drug Price Information into Electronic Medical Records
23. Resolution 220 - Accountability of 911 Emergency Services Funding
24. Resolution 221 - AMA Policy on American Health Care Act
25. Resolution 223 - Tax Deductions for Direct-to-Consumer Advertising
26. Resolution 236 - Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising
27. Resolution 224 - Medicare Prepayment and RAC Audit Reform
28. Resolution 225 - Truth In Advertising
29. Resolution 226 - Direct American Medical Association to Ask CMS and HHS to Remove Practice Expense and Malpractice Expense from Publicly Reported Payments
30. Resolution 227 - Improving Clinical Utility of Medical Documentation
31. Resolution 228 - Free Speech Applies to Scientific Knowledge
32. Resolution 229 - Medicare’s Appropriate Use Criteria Program
33. Resolution 230 - CMS Reimbursement Guidelines for Teaching Physician Supervision
34. Resolution 233 - Regulation of Physician Assistants
35. Resolution 234 - Protections for Patients with Genetic Conditions
36. Resolution 235 - Towards Eliminating ERISA State Preemption of Health Plan Liability
37. Resolution 237 - Protection of Clinician-Patient Privilege
38. Resolution 238 - Limitation on Reports to the National Practitioner Data Bank Unrelated to Patient Care
39. Resolution 241 - Timeliness in Obtaining Medical Records from Other Providers
41. Late Resolution 1001 - Barriers to Price Transparency
42. Late Resolution 1002 - Seamless Digital Interface for Best Care

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
ORDER OF BUSINESS

Reference Committee C (A-17)  
Kenneth M. Certa, MD, Chair

June 11, 2017  
Regency Ballroom C  
Hyatt Regency  
Chicago


2. Council on Medical Education Report 3, Obesity Education

3. Resolution 301, Mental Health Disclosures on Physician Licensing Applications

4. Resolution 303, Addressing Medical Student Mental Health Through Data Collection and Screening

5. Resolution 307, Formal Business and Practice Management Training During Medical Education

6. Resolution 315, Inclusion of Developmental Disabilities Curriculum in Undergraduate, Graduate and Continuing Medical Education of Physicians

7. Resolution 305, Reduction of Caregiver Burnout

8. Council on Medical Education Report 6, Standardizing the Allopathic Residency Match System and Timeline

9. Resolution 310, Breast Pump Accommodations During Medical Licensing Exams

10. Resolution 320, Cultural Competence in Standardized Patient Programs Within Medical Education

11. Council on Medical Education Report 9, Feasibility and Appropriateness of Transferring Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools

12. Resolution 309, Future of the USMLE: Examining Multi-Step Structure and Score Usage

13. Council on Medical Education Report 7, Expansion of Public Service Loan Forgiveness

14. Resolution 304, Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding
15. Resolution 308, Immigration Reform Impacts on International Medical Graduate Training and Patient Access

Resolution 311, Support of International Medical Students and Graduates

Resolution 312, Supporting International Medical Graduates and Students

Resolution 317, Immigration

Resolution 321, Continued Support of H-1B Visa Programs for International Medical Graduates

Resolution 325, Ensure an Effective H-1B Visa Program to Protect Patient Access to Care

Resolution 326, Supporting International Medical Graduates and Students


17. Resolution 313, Study of Declining Native American Medical Student Enrollment

18. Resolution 314, Educating a Diverse Physician Workforce

19. Resolution 323, Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved/Economically Depressed Areas

20. Resolution 324, Improve HRSA Projections of the Physician Workforce

21. Council on Medical Education Report 2, Update on Maintenance of Certification and Osteopathic Continuous Certification

22. Resolution 316, Action Steps Regarding Maintenance of Certification

23. Resolution 318, Oppose Direct to Consumer Advertising of the ABMS MOC Product


25. Resolution 322, Ending Maintenance of Certification Examinations

26. Resolution 302, Comprehensive Review of CME Process

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to meded@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
ORDER OF BUSINESS

Reference Committee D (A-17)
Corliss A. Varnum, MD, Chair

June 11, 2017
Hyatt Regency Chicago
Regency Ballroom D

   Resolution 414 – Imposing Taxes on Sugar-Sweetened Beverages
2. Resolution 406 – Healthful Hospital Foods
3. Resolution 407 – SNAP Reform to Improve Health and Combat Food Deserts
4. Resolution 415 – Food Bank and Pantry Distribution of Nutrient-Dense Foods
5. Resolution 402 – Destigmatizing Obesity
7. Resolution 411 – Preserving Vaccine Policy in the United States
   Resolution 1003 – Evidence-Based Vaccination Recommendations
8. Resolution 418 – Policy on Quarantine
9. Resolution 410 – Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals
10. Resolution 404 – Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons
11. Resolution 408 – Increased Oversight of Suicide Prevention Training for Correctional Facility Staff
12. Resolution 417 – Mandatory Public Health Reporting of Law-Enforcement-Related Injuries and Deaths
13. Resolution 401 – Use of Phrase “Gun Violence Mitigation” in Lieu of “Gun Control”
14. Resolution 419 – Improving Physicians’ Ability to Discuss Firearm Safety
15. Resolution 413 – Ocular Burns from Liquid Laundry Packets
16. Resolution 409 – Pediatric/Adolescent Informed Consent Concussion Discussion
18. Resolution 405 – Decreasing Screen Time and Increasing Outdoor Activity to Offset Myopia Onset and Progression in School Children

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
ORDER OF BUSINESS

Reference Committee E (A-17)
Rebecca S. Hierholzer, MD, Chair

June 11, 2017
Regency Ballroom D

2. Council on Science and Public Health Report 2 – Emerging Drugs of Abuse are a Public Health Threat
   Resolution 507 – Educating Physicians and Young Adults on Synthetic Drugs
3. Resolution 515 – Safe Use, Storage and Disposal of Leftover Opioids and Other Controlled Substances
5. Resolution 511 – Future of Pain Care
6. Resolution 526 – NIH Funding for Basic and Translational Pain Research
7. Resolution 519 – Liquid Medication Dosing
8. Resolution 520 – Combination Clotrimazole/Betamethasone Dipropionate Cream Warning
9. Resolution 521 – Retail Prescription Bottle Label Privacy
10. Resolution 525 – Providing for Prescription Drug Donation
11. Resolution 512 – Advertising Restrictions and Limited Use of Dietary Supplements
12. Resolution 517 – Choline Supplementation in Prenatal Vitamins
13. Resolution 504 – Research into Preterm Birth and Related Cardiovascular (CV) and Cerebrovascular Risks (CVD) in Women
14. Resolution 503 – Women and Mental Health
16. Resolution 523 – AMA Support for Evidence-Based Environmental Statutes and Regulations
17. Resolution 501 – Airplane Emissions
18. Resolution 510 – Ban on the Use of Paraquat
19. Resolution 514 – Retinoblastoma Due to Pre-Natal Residential Pesticide Exposure
21. Resolution 516 – In-Flight Emergencies
22. Resolution 509 – Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research
24. Resolution 518 – Recognition of Infertility as a Disease

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to ReferenceCommitteeE@gmail.com or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
25. Resolution 513 – Supervised Injection Facilities
Resolution 524 – Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis
ORDER OF BUSINESS

Reference Committee F (A-17)
Gary R. Katz, MD, MBA, Chair

June 11, 2017
Hyatt Regency Chicago
Grand Ballroom
Chicago

Financial
1. Board of Trustees Report 1 – Annual Report
2. Report of the House of Delegates Committee on the Compensation of the Officers
3. Board of Trustees Report 4 – AMA 2018 Dues
4. Board of Trustees Report 10 – Creation of an AMA Fund for Physician Candidates
5. Resolution 607 – AMA to Protect Human Health from the Effects of Climate Change by Ending Its Investments in Fossil Fuel Companies (Divestment)

House of Delegates
7. Board of Trustees Report 17 – Equality for Future Meetings Organized or Sponsored by the AMA
8. Board of Trustees Report 23 – Anti-Harassment Policy

Governance
9. Resolution 601 – Reinstate the AMA Commission to End Health Care Disparities
10. Resolution 603 – Sexual Orientation and Gender Identity Demographic Collection by the AMA
11. Resolution 604 – High Cost to Authors for Open Source Peer Reviewed Publications
12. Resolution 606 – Add Patients to the AMA Mission Statement
13. Resolution 608 – Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine
Medical Practice

14. Resolution 602 – Studying Healthcare Institutions that Provide Child Care Services

15. Resolution 605 – Pronunciation of Pharmaceutical Names

16. Resolution 609 – Model Hospital Medical Staff Bylaws

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to steve.currier@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, propose amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
ORDER OF BUSINESS

Reference Committee G (A-17)
J. Clay Hays, Jr., MD, Chair

June 11, 2017
Hyatt Regency Chicago
Regency Ballroom A
Chicago

1. Board of Trustees Report 9 – Physician and Medical Staff Member Bill of Rights
2. Board of Trustees Report 18 – Eliminate the Requirement of H&P Update
4. Council on Medical Service Report 5 – Hospital Consolidation
6. Board of Trustees Report 12 – Unforeseen Consequences of Core Measures
   Resolution 704 – Prior Authorization Abuse
9. Resolution 707 – Inclusion of Continuing Care Retirement Centers & Long-Term Care Facilities in Accountable Care Organizations Investment Model
10. Resolution 708 – Removing ‘Three Star Minimum’ Requirement for Skilled Nursing Facilities to Participate in Next Gen Accountable Care Organizations & Bundled Payments for Care Improvement Programs and Care for Patients with Waiver of Three Night Hospital Stay Requirement
12. Resolution 702 – Credentials/Specialty Added to Clinical Note Signatures
13. Resolution 703 – Certified Translation Services
   Resolution 710 – Payment for Medicaid Interpreter Services
14. Resolution 705 – Regulating Health Plans Medical Advice
15. Resolution 706 – Concurrent and Overlapping Surgery
17. Resolution 714 – Timely Referral to Pain Management Specialist
18. Resolution 709 – Management of Physician and Medical Student Stress
20. Resolution 712 – Pay-for-Performance Incentives
21. Resolution 713 – Urge AMA to Release a White Paper on ACOs
22. Resolution 717 – Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit
23. Board of Trustees Report 20 – Study the Minimum Competencies and Scope of Medical Scribe Utilization
25. Resolution 715 – Prescription Availability for Weekend Discharges
26. Resolution 719 – System Approach to Medical Staff Governance
27. Resolution 720 – Medical Staff Non-Punitive Reporting Processes
28. Resolution 721 – Secret Ballots in Medical Staff Voting Processes

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities in preparation for the 2018 Elections. Our mission remains to provide physicians with opportunities to support candidates for election to federal office who have demonstrated their support for organized medicine, including a willingness to work with physicians to strengthen our ability to care for America’s patients. In addition, we continue to help physician advocates through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully work on a campaign or to run for office themselves. We work hand-in-hand with our state medical society PAC partners to carry out our mission.

**AMPAC Membership Fundraising**

In the 2016 election cycle, AMPAC raised nearly $2.4 million dollars and played a significant role in influencing 2016 election outcomes. In total, AMPAC invested nearly $2 million in the 2016 cycle and achieved a 91 percent success rate of supported candidates. With the 2018 midterm elections well underway, it is critical that AMPAC’s participation be at an all-time high in order to remain effective this election cycle.

The 2017 HOD AMPAC participation is currently at 48 percent—a 4 percent decrease from the 2016 Annual meeting. As AMPAC strives to surpass last year’s record breaking HOD AMPAC participation of 76 percent, we will remain focused on obtaining a greater number of HOD Capitol Club members. Of the current 48 percent of HOD members that participate in AMPAC, 37 percent participate at the Capitol Club level. HOD Capitol Club participation has 188 members including 26 Platinum members, 75 Gold members and 87 Silver members. For those of you who have contributed to AMPAC already in 2017—thank you! For those of you who haven’t, we need your support now more than ever. If you have not made a 2017 contribution to AMPAC yet, I strongly encourage you to stop by the AMPAC booth today to join or renew your membership.

All current 2017 Capitol Club members have been invited to attend an exclusive Capitol Club Luncheon on Tuesday, June 13th with special guest Jon Meacham. Mr. Meacham is a renowned presidential historian, Pulitzer Prize winning author and #1 New York Times best-selling author. He is also a contributing writer to The New York Times Book Review and contributing editor at TIME. He will explore how past presidents have shaped this country and how it relates to the current administration.

AMPAC is also excited to announce its 2017 Festival of Fall Colors Sweepstakes. The name of the lucky winner will be announced at the Interim Meeting in Honolulu, Hawaii during the opening HOD session. The winner will receive accommodations for 4 days/3 nights at Twin Farms Resort and Spa in Barnard, Vermont in September 2018. This trip will include all-
inclusive full service custom dining options, unlimited cocktails, a variety of daily on-property guided activities and access to the fitness center and spa. Current 2017 Platinum, Gold and Silver contributors are automatically entered into the drawing for the sweepstakes.

**Political Action**

The first half of this year has been a busy time for Congress to say the least. Issues of keen interest to medicine such as health system reform, drug price transparency and the ongoing opioid epidemic are coming into focus and AMPAC has a role in helping to ensure medicine has a place at the table. With these and other important issues in mind, we are preparing for another robust election cycle in 2018. The AMPAC Board’s Congressional Review Committee is working to lay the groundwork for early 2018 Primary contributions to House and Senate candidates. Medicine-friendly candidates, lawmakers in positions of leadership or on committees that deal with medicine’s top issues, in addition to those legislators who are otherwise in unique positions to favorably impact key legislation are our top priorities.

Still roughly 18 months away from the mid-term elections, the national political landscape is extremely volatile and uncertain. AMPAC will remain a reliable constant for medicine and continue to be involved with important U.S. House and Senate races all over the country.

**Political Education Programs**

On February 18-19, 22 physicians and medical students took part in AMPAC’s 2017 Candidate Workshop, held at the AMA’s Washington, DC headquarters. Participants were provided a hands-on learning experience featuring political experts from both sides of the aisle providing expert instruction on how to run a winning campaign. Sessions included topics such as: effective fundraising techniques, crisis management, public speaking, grassroots organization and, in general, how to run a disciplined campaign.

Building on the success of this new programmatic model AMPAC is proud to announce that the dates for the 2017 Campaign School have been set for October 27-29 at the AMA Washington, DC offices. Running an effective campaign can be the difference between winning and losing a race. The AMPAC Campaign School is designed to give participants the skills and strategic approach they will need out on the campaign trail. Our team of political experts will teach them everything they need to know to run a successful campaign.

For more information on any of the Political Education Programs you are encouraged to stop by the AMPAC and AMA Grassroots booths during this meeting, or by visiting ampaconline.org.

**Conclusion**

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.
Informational Reports

BOT Report(s)
03 2016 Grants and Donations
05 Update on Corporate Relationships
06 Redefining AMA's Position on ACA and Healthcare Reform
07 AMA Performance, Activities and Status in 2016
08 Annual Update on Activities and Progress in Tobacco Control: March 2016 Through February 2017
21 Risk Adjustment Refinement in Accountable Care Organization Settings and Medicare Shared Savings Programs
24# Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care

CEJA Opinion(s)
01 Collaborative Care

CEJA Report(s)
05 Study Aid-in-Dying as End-of-Life Option
06 Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient-Centered, Safe Care Services
07 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

CLRPD Report(s)
02 Demographic Characteristics of the House of Delegates and AMA Leadership

CME Report(s)
04 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages
05 Options for Unmatched Medical Students
08 ACCME Proposed Changes in "Accreditation with Commendation" Continuing Medical Education Criteria Assessment Methodology

CMS Report(s)
02 Health Care Financing Models

Report of the Speakers
01 Recommendations for Policy Reconciliation

* Contained in Handbook Addendum
# Contained in Sunday Tote
Subject: Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care

Presented by: Patrice A. Harris, MD, MA, Chair

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

EMGAGEMENT WITH CONGRESS AND THE TRUMP ADMINISTRATION

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

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

On March 6, 2017, the House Republican leadership introduced the American Health Care Act (AHCA) (H.R. 1628), legislation to repeal and replace several major provisions of the ACA. The bill was introduced in two parts due to jurisdictional issues, and was marked up by the House Energy and Commerce Committee and the House Ways and Means Committee on March 8. However, due to a split in policy approaches between conservative House Republican members and more moderate and centrist members, leadership struggled to attract sufficient votes to bring the bill to the floor for a vote. Facing increased pressure from the White House to schedule a vote and after several substantive amendments were made to bring several conservatives on board, the House of Representatives narrowly passed an amended version of the AHCA on May 4 by a vote of 217 to 213. House Democrats unanimously opposed the legislation. Twenty Republicans also voted against the legislation.

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

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

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

GRASSROOTS AND MEDIA ACTIVITIES

On March 13, the AMA launched a new microsite aimed at encouraging physicians and patients to
join the AMA’s fight to increase access to affordable, meaningful coverage for everyone in our
nation. Patientsbeforepolitics.org is an interactive site that provides physicians and patients with
the latest information on health care reform legislation moving through Congress, as well as the
AMA’s current efforts to help shape the future of U.S. health care. The site features an easy way
for both patients and physicians to contact members of Congress—urging them to protect patients
currently insured, enable low and moderate income people to secure meaningful coverage, and
maintain Medicaid and other safety net programs. The site also includes numerous AMA policy
briefs and Council on Medical Service reports on different aspects of health insurance and market
reform, Medicaid, and additional AMA objectives for health system reform.

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

ENGAGEMENT WITH FEDERATION AND PATIENT AND PROVIDER GROUPS

In addition to the AMA’s engagement with the Federation through meetings and conference calls,
the AMA also has collaborated with an array of patient advocacy groups, hospitals, and other
health care stakeholders in raising core objections to the AHCA’s underlying approach to fixing the
imperfections of the ACA. On March 16, the AMA held a news conference in Washington, DC,
along with three major organizations representing patients—the American Cancer Society Cancer
Action Network (ACS-CAN), the American Diabetes Association, and the American Heart
Association—to express joint concerns over the AHCA. On April 13, the AMA and seven other
organizations representing family physicians, hospitals, businesses, employers, and health insurers,
sent letters to the Trump Administration and to Congressional leaders expressing concerns over
continued funding for the cost-sharing reduction (CSR) program under the ACA to help lower
health care costs for low- and moderate-income individuals. The AMA also collaborated on a joint
op-ed on the CSR issue with the American Heart Association and ACS-CAN, which was published
in the Hill newspaper on April 26. Additional engagement with physicians and patients occurred
through six physician focus groups in March and April—in Philadelphia, Chattanooga, and
Phoenix—that focused on AMA health system reform principles and messaging and broader health
system and delivery issues. In April, patient-physician roundtables were convened in Denver and
Atlanta in collaboration with the state medical societies and AARP, ACS-CAN, and the American
Heart Association, to gather additional input on the ACA’s successes and shortcomings. The
AMA’s outreach to the Federation, patient groups, and other provider and health organizations will
continue as the debate over health system reform proceeds in the Senate.
Whereas, Donald W. Fisher, PhD, CAE, American Medical Group Association president and chief executive officer, passed away on March 26, 2017; and

Whereas, Dr. Fisher has been at the helm of AMGA since 1980, leading it to become the voice of multispecialty medical groups and integrated systems of care; and

Whereas Dr. Fisher had a personal impact on American health care as a strong advocate for coordinated, integrated delivery systems, working to make his vision of superior care a reality; and

Whereas, Dr. Fisher earned recognition of group practice care as a specialty by AMA and thereby gained AMGA a seat in the AMA House of Delegates; and

Whereas, Dr. Fisher earned a BS in biology/chemistry from Millsaps College in 1968, his MS in anatomy from the University of Mississippi, School of Medicine in 1971 and a PhD in anatomy from the University of Mississippi in 1973. His passion was health care, and he served on numerous related boards and councils as well as received many honors, including the Russell V. Lee Lectureship and the Presidential Award from the American Academy of Physician Assistants; and

Whereas Dr. Fisher’s passion for health care and improving the lives of patients were rivaled only by his dedication, humor, and intellect; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. Fisher’s dedication to advancing the best possible patient care, to leading with integrity; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family members of Donald W. Fisher, PhD, CAE.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Virginia “Ginger” Tullis Latham, MD

Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Senior Physicians Section

Whereas, Virginia “Ginger” Tullis Latham, MD, was born on May 28, 1940, and passed away on April 21, 2017; and

Whereas, Dr. Latham resided in Harvard, MA, where she lived with her beloved husband, David W. Latham, Sr., with whom she shared 57 years of marriage. Ginger, who had a great love of learning, graduated from Beaver Country Day School in Chestnut Hill, MA and then went on to Duke University as a Honorary Duke National Scholar. She graduated from Boston University. After raising 5 sons, Ginger enrolled in Harvard Medical School and completed her residency in Internal Medicine in 1981; and

Whereas, Dr. Latham was a well-respected and beloved member of the Emerson Hospital community; and

Whereas, Dr. Latham took great pleasure in leadership roles for Harvard town activities including the local Garden Club Board, the Harvard Woman’s Club (HWC) and a weekly bridge group of the HWC in conjunction with the Harvard Committee on Aging; and

Whereas, Dr. Latham has been a member of the Massachusetts Medical Society (MMS) and the Middlesex Central District Medical Society for over 30 years; and

Whereas, Dr. Latham was president of the Massachusetts Medical Society in 2000 and was the third female to become president in MMS history; and

Whereas, Under Dr. Latham’s presidency, the Society made its mark in the area of patient safety, with the passage of the landmark Patient Bill of Rights, as well as providing strong support for patient privacy and confidentiality, as new regulations in the Health Insurance Portability and Accountability Act came into being. She also co-chaired the search committee for a new editor for the New England Journal of Medicine—an activity that resulted in the appointment of the current editor, Dr. Jeffrey Drazen; and

Whereas, Dr. Latham was a member of many MMS committees, including Strategic Planning, Senior Physicians, Women Physicians, Judicial, Finance, Board of Trustees, Medical Student Debt Reduction, and the House of Delegates, to name a few; and

Whereas, Dr. Latham was a member of the MMS’s American Medical Association’s Delegation for many years; and

Whereas, Dr. Latham was a member of the AMA Senior Physicians Group Governing Council and a driving force in its becoming a Section of AMA House of Delegates with a voting seat, always striving, as she had throughout her career, for a voice for physicians (of all ages) to be advocates for the patients for whom they care; and

Whereas, Dr. Latham was honored at the 2016 Interim Meeting of the MMS House of Delegates with a Presidential Citation in recognition of a career in medicine exemplary of the highest traditions, ideals, and aspirations of the MMS; therefore be it

RESOLVED, That our American Medical Association note with great sadness the passing of Virginia Tullis Latham, MD, with thankfulness and gratitude for the gift of her life and work; and be it further

RESOLVED, That expressions of condolence be forwarded with a copy of this memorial resolution to the Latham family.
Whereas, Dr. Jerry McLaughlin, a dedicated Obstetrician and Gynecologist who delivered over 6,000 babies and touched countless lives, was greatly revered by his patients, fellow physicians and all those for whom he cared and with whom he worked; and

Whereas, Dr. Jerry McLaughlin was an active and giving member of the communities in which he lived, and greatly beloved by his wife, children and extended family; and

Whereas, Dr. Jerry McLaughlin was a tireless and eloquent advocate for organized medicine and our profession, and an inspiration and mentor for medical students, residents and young physicians, many of whom developed a love of organized medicine under his gentle tutelage; and

Whereas, Dr. Jerry McLaughlin represented the physicians of New Mexico and Texas with distinction on the national stage over the decades of his medical career, in roles including: Delegate to the AMA Young Physician's Section, Alternate Delegate to the AMA House of Delegates from both New Mexico and Texas, Delegate to the AMA House of Delegates from New Mexico, Chairman and Member of multiple AMA Reference Committees including Reference Committee F, and member of the Governing Council of the United States Pharmacopoeia; and

Whereas, Dr. Jerry McLaughlin honorably served the New Mexico Medical Society in roles including: Vice speaker, President, Councilor, Executive Council Member, New Mexico Medical PAC Member, Special Lecturer, and member of various liaison committees; and

Whereas, Dr. Jerry McLaughlin also served his local New Mexico community as both Lea County Medical Society Member and President; and

Whereas, When Dr. McLaughlin left New Mexico for a new opportunity in Texas, the New Mexico Medical Society commissioned the “Jerry McLaughlin Service Award,” to recognize outstanding and lasting commitment to the Medical Society and the community, to be awarded in perpetuity to deserving NMMS members; and

Whereas, Dr. Jerry McLaughlin was one of the very few people in this world who could pull off wearing a red blazer and red cowboy boots for dress-up clothes; and

Whereas, Dr. Jerry McLaughlin’s tragic and untimely death on January 20, 2017 was devastating for all those who knew and loved him; therefore be it

RESOLVED, That the House of Delegates of our American Medical Association rise in appreciation and remembrance of our esteemed and distinguished colleague and friend, Jerry Dewayne McLaughlin II, MD.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Richert E. Quinn, MD

Introduced by Colorado

Whereas, Richert E. Quinn Jr., MD, passed away Jan. 11, 2017 at the age of 75. Quinn was a loving husband, father and grandfather; a respected general surgeon in Greeley who was instrumental in establishing and then leading the burn unit at the Weld County Hospital; a leader in the American Medical Association, Colorado Medical Society, Weld County Medical Society and Northern Colorado Medical Society; and a visionary who helped establish COPIC Insurance Company (COPIC) and contribute to its tremendous success; and

Whereas, “Dr. Richert Quinn really believed in and embodied that we were part of a profession,” said Alan Lembitz, MD, COPIC’s chief medical officer, who got to know Quinn as a resident physician. “He taught that we had a special role and responsibility to our patients, but he also led by example that we as physicians had a duty to each other to make this profession of medicine better. Rich worked tirelessly in the ‘house of medicine,’ but also was just as dedicated one on one in what today we call mentoring”; and

Whereas, “Never at a loss for words, nor short of an opinion, Rich got things done sometimes by sheer force of will,” Lembitz continued. “I enjoyed his big heart, his self-deprecating sense of humor and his devotion to others. ‘If I see further today it is only because I stand on the shoulders of giants’ might seem like an odd hyperbole for this setting, but to me it defines what made Rich Quinn’s contributions and attitude special to our profession. He was a wise and good soul, and he will be missed”; and

Whereas, Quinn served as CMS president in 1985-1986 and was elected a delegate to the AMA in 1986. CMS President-elect M. Robert Yakely, MD, was chairman of the CMS Council on Legislation during Quinn’s tenure as CMS president. “During that period we worked together closely on getting legislation on tort reform that has continued to protect Colorado physicians to this day. Rich was a leader in this effort and a visionary for our society in this area. He saw the need to form coalitions with other interested parties. It took several years to develop this coalition, but he never wavered in his effort to achieve this milestone goal much to the benefit of all the physicians of Colorado”; and

Whereas, “Through his leadership and direction the delegation to the AMA was able to pass many strategic resolutions and elect numerous delegates’ important positions within the AMA,” said Ray Painter, MD, past president of CMS and a leader of the Colorado delegation to the AMA. “Dr. Quinn was a very trusted friend to many and liked by all for his commitment, humility and sense of humor”; and

Whereas, AMA Past President Jeremy Lazarus, MD, calls Quinn a true friend and mentor who was “unassuming, humble, tactically astute and collegial in a very special way.” Quinn helped Lazarus gain the experience needed to run for AMA office and then helped him achieve that office. “He led our AMA delegation with great dignity and was a trailblazer when he was elected to the AMA’s Council on Constitution and Bylaws. He went on to chair that council with the same solid performance that he had always shown,” Lazarus said; and
Whereas, Quinn joined the COPIC board in 1986 and served for nearly 10 years before stepping off to become the vice president of COPIC’s Risk Management Department. Jerry Buckley, MD, past chairman and CEO of COPIC, credits Quinn with "raising the bar of patient safety and quality to such a degree in Colorado that it was considered the gold standard of medical liability insurance companies not only in the United States but worldwide"; and

Whereas, “Rich was the consummate risk manager, equally concerned for both the patient and the physician provider in any medical intervention,” Buckley continued. “His unique style of first telling you all the things you did correct captured your attention so you would be totally open to learn from what did not go as you anticipated. His love of medicine was only exceeded by his love for his wife, Carol, and children, Kevin and Shannon, and their beautiful children,” Buckley said. “I loved him, his sense of humor and have no one to replace his special charm”; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and commend Dr. Richert E. Quinn’s life of service to all who knew him; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family of Richert E. Quinn, MD.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Richert E. Quinn, Jr., MD

Introduced by the Senior Physicians Section

Whereas, Dr. Richert “Rich” Edward Quinn, Jr., MD, a Greeley, Colorado surgeon, passed away on January 11, 2017; and

Whereas, Dr. Quinn graduated from the University of Missouri in Columbia, and completed a surgical residency at St. Joseph Hospital in Denver; and

Whereas, Following his education he moved to Greeley, Colorado, where he practiced at the Greeley Medical Clinic for the next two decades and cared for hundreds of patients; and

Whereas, During his extensive surgical career, he spent time as the Medical Director for the Greeley Medical Clinic, and was named Chair of the Department of Surgery at North Colorado Medical Center, and later served as Director of the Burn Unit at NCMC, a specialized care center he helped to create; and

Whereas, Dr. Quinn was elected to the AMA House of Delegates, serving from 1985 to 2011, and the AMA Senior Physicians Section from 2009 to 2014, serving as Chair his last year; and

Whereas, Dr. Quinn's knowledge of AMA issues and his quiet, effective manner led to a high degree of respect in our AMA House of Delegates; and

Whereas, Dr. Quinn became a valued member of the AMA Council on Constitution and Bylaws, ultimately serving as chair of that council; and

Whereas, Dr. Quinn was a key figure in the development and recognition of our AMA Senior Physicians Section; and

Whereas, Dr. Quinn was highly respected as a compassionate surgeon who demonstrated through his actions that his responsivity is to patients first and foremost; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Doctor Richert E. Quinn’s outstanding service to the profession; and be it further

RESOLVED, That a copy of this resolution be recorded in the Proceedings of this House and be forwarded to his family with an expression of the House’s deepest sympathy.
Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)
02 New Specialty Organizations Representation in the House of Delegates
15 No Compromise on Anti-Female Genital Mutilation Policy
19# CEJA and House of Delegates Collaboration (REVISED Page 3)
25# Specialty Society Representation in the House of Delegates - Five-Year Review

CC&B Report(s)
01 Updated Bylaws - Emergency Business
02 Specialty Society Allocation for House of Delegates Representation

CEJA Report(s)
01 Amendment to E-2.3.2, "Professionalism in Social Media"
02 Competence, Self-Assessment and Self-Awareness
03 Ethical Physician Conduct in the Media
04 CEJA's Sunset Review of 2007 House Policies

CLRPD Report(s)
01 Delegate Allocation for Specialty Societies

Resolution(s)
001 Participation of Physicians on Healthcare Organization Boards
002 Care of Women and Children in Family Immigration Detention
003 Medical Spectrum of Gender
004 Moved to Reference Committee D (now Resolution 418)
005 Perioperative Do No Resuscitate Orders
006 Increasing Access to Healthcare Insurance for Refugee Populations
007 Healthcare as a Human Right
008 Promoting the Use of Appropriate LGBTQIA Language in Medical Documentation
009 Commercial Exploitation and Human Trafficking of Minors
010 Access to Basic Human Services for Transgender Individuals
011 Revision of Researcher Certification and Institutional Review Board Protocols
012* Promoting the AMA Model Medical Staff Code of Conduct and its Application to Employed Physicians
013* Gender Identity Inclusion and Accountability in REMS
014* The Need to Distinguish Between Physician Assisted Suicide and Aid in Dying
015* Appropriate Placement of Transgender Prisoners
016# Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents
017# Improving Medical Care in Immigrant Detention Centers
018# Patient and Physician Rights Regarding Immigration Status
019# Who Owns Our Patients' Data?
020# Recognition of Physician Orders for Life Sustaining Treatment (POLST)

* Contained in Handbook Addendum
# Contained in Sunday Tote
The recommendations of this report were adopted as presented and are reflected in current Bylaws relating to the Council on Ethical and Judicial Affairs discussed below.

**Current CEJA Practice**

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

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

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

**RELEVANT AMA POLICY**

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

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

**OPPORTUNITIES TO ENHANCE COLLABORATION**

The Board of Trustees concurs that, as the 1991 CEJA-CCB joint report argued, balancing independence and oversight are key for productive, collegial collaboration between the Council on Ethical and Judicial Affairs and the House of Delegates. The integrity and stature of the *Code of*
The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2017 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, “Summary of Guidelines for Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic Review Process.”

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

The following organizations were reviewed for the 2017 Annual Meeting:

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

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

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

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

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

RECOMMENDATIONS

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


2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.50, the Academy of Physicians in Clinical Research and the American Society of General Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year’s grace period to increase membership, the American Association of Hip and Knee Surgeons and American Society of Neuroimaging not retain representation in the House of Delegates. (Directive to Take Action)

Fiscal Note: Less than $500
## APPENDIX

### Exhibit A - Summary Membership Information

<table>
<thead>
<tr>
<th>Organization</th>
<th>AMA Membership of Organization’s Total Eligible Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy of Physicians in Clinical Research</td>
<td>97 of 257 (38%)</td>
</tr>
<tr>
<td>American Association of Hip and Knee Surgeons</td>
<td>346 of 2,250 (15%)</td>
</tr>
<tr>
<td>American Society for Reproductive Medicine</td>
<td>983 of 2,933 (34%)</td>
</tr>
<tr>
<td>American Society of General Surgeons</td>
<td>65 of 247 (26%)</td>
</tr>
<tr>
<td>American Society of Neuroimaging</td>
<td>82 of 267 (30%)</td>
</tr>
<tr>
<td>American Thoracic Society</td>
<td>1,581 of 8,056 (20%)</td>
</tr>
<tr>
<td>College of American Pathologists</td>
<td>1,497 of 10,514 (14%)</td>
</tr>
<tr>
<td>Congress of Neurological Surgeons</td>
<td>774 of 3,470 (22%)</td>
</tr>
<tr>
<td>Contact Lens Association of Ophthalmologists, Inc.</td>
<td>52 of 179 (22%)</td>
</tr>
<tr>
<td>International College of Surgeons – US Section</td>
<td>263 of 737 (36%)</td>
</tr>
<tr>
<td>Society for Cardiovascular Angiography and Interventions</td>
<td>420 of 2,013 (21%)</td>
</tr>
<tr>
<td>Society for Investigative Dermatology, Inc.</td>
<td>310 of 860 (36%)</td>
</tr>
<tr>
<td>Society of Interventional Radiology</td>
<td>680 of 3255 (20%)</td>
</tr>
<tr>
<td>United States and Canadian Academy of Pathology</td>
<td>1,303 of 7,080 (18%)</td>
</tr>
</tbody>
</table>
Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

2. The organization must:

   (a) represent a field of medicine that has recognized scientific validity;
   (b) not have board certification as its primary focus; and
   (c) not require membership in the specialty organization as a requisite for board certification.

3. The organization must meet one of the following criteria:

   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.

5. Physicians should comprise the majority of the voting membership of the organization.

6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.

7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.
Exhibit C

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

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.
Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

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

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

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

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

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

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

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

Resolution: 016
(A-17)

Introduced by: Young Physicians Section

Subject: Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings against their Undocumented Parents

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Michael Hoover, MD, Chair)

Whereas, The number of children in foster care has increased from 397,605 in Fiscal Year (FY) 2011 to 427,910 in FY 2015 (after declining more than 20% between FY 2006 and FY 2012); and

Whereas, The number of children born in the U.S. with one or both of their parents as undocumented represents 8% of the 3.9 million US births in 2013; and

Whereas, Under the 14th Amendment of the U.S. Constitution any person born in the U.S. is granted automatic citizenship; and

Whereas, The risk of deportation and detention decreases utilization of healthcare services, increases family stress, increases financial hardship, and decreases parental availability, results in frequent moves disrupting education, and decreases enrollment in preschool; and

Whereas, Deportation without access to a hearing risks the safety of the individuals being deported and risks the stability of the families involved; and

Whereas, The poverty rate for single mother families is 40.7%, compared to 24.2% for single father families, and men were nearly two times as likely as women to be detained and deported, thus increasing the economic strain for immigrant families; and

Whereas, At least 5,100 children are currently in the U.S. foster care system and cannot be reunited with their parents due to the parents’ detention or deportation--and 15,000 more children could face similar circumstances in the next five years; and

Whereas, Approximately 300,000 U.S. born children followed their parents back to Mexico between 2005 and 2012, resulting in loss of the benefits associated with U.S. citizenship, such as access to health insurance; and

Whereas, While U.S. citizen minors are eligible for social service benefits, research shows that undocumented parents underuse the social services available to their children, due to fears of the implications of disclosing their legal status in the application process; therefore be it

RESOLVED, That our American Medical Association support that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported (New HOD Policy); and be it further
RESOLVED, That our AMA work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation. (Directive to Take Action)

Fiscal Note: Modest: between $1,000 - $5,000.

Received: 6/9/2017

RELEVANT AMA POLICY

H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care.
2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents. (Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14)

Financial Impact of Immigration on American Health System D-160.988
Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid. (Res. 235, A-06 Reaffirmation I-10)

References:
3. https://www.law.cornell.edu/constitution/amendmentxiv
AMERICAN MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution: 017
(A-17)

Introduced by: Medical Student Section

Subject: Improving Medical Care in Immigrant Detention Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

(Michael Hoover, MD, Chair)

Whereas. The United States has the largest immigration detention structure in the world with over 600 facilities detaining between 380,000 to 442,000 persons per year;¹

Whereas, The U.S. Immigration and Customs Enforcement (ICE) is a federal agency that also contracts with private detention centers where more than half of detainees are held;²,³

Whereas, The White House has issued immigration executive orders to expand authority for immigration officers, dramatically increase efforts to detain and deport undocumented immigrants, and increase the number of immigrant detainees in ICE facilities;¹¹ and

Whereas, A total of 167 deaths have occurred in ICE detention facilities from 2003 to present,⁴,¹³ and six of eight deaths due to substandard medical care between 2010 and 2012 occurred in for-profit immigrant detention facilities;⁵ and

Whereas, Despite substandard health conditions in private detention facilities, ICE continues to utilize these facilities to control costs and handle increased numbers in detention;\(^6,7\) and

Whereas, ICE detention facilities have failed to prevent human rights abuses, substandard living conditions, and inconsistent access to quality medical, dental, and mental care;\(^5,8-12\) and

Whereas, The ICE Office of Detention Oversight and the Enforcement and Removal Operations have provided data, demonstrating that substandard medical care in immigrant detention facilities has led to preventable deaths, yet deficient ICE inspections in spite of the PBNDS allows for these issues to continue or worsen;\(^8\) therefore be it

RESOLVED, That our American Medical Association issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees (Directive to Take Action); and be it further

RESOLVED, That our AMA recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000.

Date received: 06/10/17

RELEVANT AMA POLICY:

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. Res. 60, A-84 Reaffirmed by CLRPD Rep. 3 - I-94 Amended: Res. 416, I-99 Reaffirmed: CEJA Rep. 8, A-09 Reaffirmation I-09 Modified in lieu of Res. 502, A-12 Reaffirmation: I-12

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups
to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.


Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and

(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities. Res. 440, A-04 Amended: BOT Action in response to referred for decision Res. 602, A-00 Reaffirmation I-09 Reaffirmation A-11 Reaffirmed: CSAPH Rep. 08, A-16 Reaffirmed: CMS Rep, 02, I-16

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. CSA Rep. 4, A-03 Modified: CSAPH Rep. 1, A-13

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.

7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women. CMS Rep. 02, I-16

**Shackling of Pregnant Women in Labor H-420.957**

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:

   - An immediate and serious threat of harm to herself, staff or others; or
   - A substantial flight risk and cannot be reasonably contained by other means.

   If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. Res. 203, A-10
Whereas, On January 25, 2017 the President of the United States signed two executive orders that significantly increased the number of undocumented immigrants targeted for deportation, expanded the size and powers of U.S. Immigration and Customs Enforcement (ICE) and U.S. Customs and Border Protection (CBP), and urged government “to employ all lawful means to enforce the immigration laws of the United States”; and

Whereas, Stringent immigration policies and the fear of deportation contribute to decreased use of preventive health care and poorer health outcomes among undocumented patients; and

Whereas, Recent literature has called for physicians to determine their patient’s immigration status as a clinically significant aspect of their social history; and

Whereas, Medical records have been used by researchers to determine patients’ immigration statuses, and thus may be viewed by immigration enforcement officials as a potential source of actionable information; and

Whereas, A “covered entity” is defined as “(1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered [under 45 CFR Chapter A Subchapter C]”; and

Whereas, Medical Student Section
Subject: Patient and Physician Rights Regarding Immigration Status
Referred to: Reference Committee on Amendments to Constitution and Bylaws (Michael Hoover, MD, Chair)
Whereas, According to current HIPAA law: A covered entity may disclose some protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a fugitive, suspect, material witness or missing person, including name, address, date and place of birth;\textsuperscript{16} and

Whereas, A covered entity may disclose any protected health information to law enforcement pursuant to a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, a grand jury subpoena, or an administrative subpoena or summons under certain conditions;\textsuperscript{17} and

Whereas, Current HIPAA law does not explicitly protect patient information from use by ICE, CBP or other law enforcement for the purpose of immigration enforcement;\textsuperscript{18} and

Whereas, Current AMA policy strongly opposes any federal legislation requiring physicians to establish the immigration status of their patients (H-270.961); and

Whereas, Current AMA policy opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status (H-440.876); and

Whereas, No AMA policy exists that addresses the disclosure of patient immigration status if requested by federal authorities or access to medical records by federal authorities; therefore be it

RESOLVED, That our American Medical Association support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (New HOD Policy)

Fiscal Note: Modest – Between $1,000 - $5,000.

Date received: 06/10/17

RELEVANT AMA POLICY:

Financial Impact of Immigration on the American Health System H-160.920
Our AMA supports legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient.

Medical Care Must Stay Confidential H-270.961
Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.

\textsuperscript{15} 45 CFR 160.103
\textsuperscript{16} 45 CFR 164.512(f)(2)
\textsuperscript{17} 45 CFR 164.512(f)(1)
\textsuperscript{18} 45 CFR 164.512(f)
Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

Racial and Ethnic Disparities in Health Care H-350.974
Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

The AMA emphasizes three approaches that it believes should be given high priority:

(1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

(2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

(3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
Whereas, The question of who will maintain the medical records for physicians’ patients, and how the physician, his or her patients, and other parties will be given access to those records is a complicated one with the potential to create controversy and ill will; and

Whereas, State laws vary on the issue of who actually “owns” a patient’s medical record—some states have enacted statutes that specifically grant ownership of a medical record to the physician or health care organization that generates the record, while others have no clear statutory authority regarding “ownership” of a patient’s medical record; and

Whereas, In many situations involving the transition of a physician from one practice to another, the issue of ownership of patient medical records is critical, as the physician, health care organization, or other third party that possesses the medical records can control the degree to which patients and other physicians can access the records; and

Whereas, Delays in receiving copies of patients’ medical records can force the postponement of required medical care; therefore be it

RESOLVED, That our American Medical Association undertake a study of the use and misuse of patient information by hospitals, corporations, insurance companies, or big pharma, including the impact on patient safety, quality of care, and access to care when a patient’s data is withheld from his or her physician, with report back at the 2018 Annual Meeting. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000

Received: 06/10/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(A-17)

Introduced by: Organized Medical Staff Section

Subject: Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael Hoover, MD, Chair)

Whereas, Physician Orders for Life Sustaining Treatment (POLST) forms are recognized in nearly every state; and

Whereas, It is not uncommon for an individual with a valid POLST form to cross state lines to visit or stay with a family member for a period of time; and

Whereas, The AMA has existing policy on end-of-life care, which is supportive of patient needs but does not address the concern of portability when venturing away from one’s home state (AMA Policy H-85.957); therefore be it

RESOLVED, That our American Medical Association advocate with appropriate government, legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment forms completed in one state as valid and enforceable in other states (Directive to Take Action); and be it further

RESOLVED, That our AMA create a universal Physician Orders for Life Sustaining Treatment form that would be valid and enforceable in all states. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000

Received: 06/10/17

RELEVANT AMA POLICY

H-85.956 Educating Physicians about Advance Care Planning

Our AMA:
1. Will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient’s advance care decisions;
2. Supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act;
3. Encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles
guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment;

4. Will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; and

5. Encourages development of a model educational module for the teaching of advance directives and advance care planning.

(CCBA CLRPD Report 3 A-14 Appended; Resolution 307, A-14 A-17 Reaffirmed; BOT Report 05, I-16)

H-140.966 Decisions Near the End of Life
Our AMA believes that:

1. The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

2. There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

3. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

4. Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.

5. Our AMA supports continued research into and education concerning pain management.


H-85.957 Encouraging Standardized Advance Directives Forms within States
Our AMA encourages each state society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients. (Resolution 5, I-11 I-17 Reaffirmed: BOT Report 05, I-16)
Reference Committee A

CMS Report(s)
01 Council on Medical Service Sunset Review of 2007 AMA House Policies
03 Ensuring Continuity of Care Protections During Active Courses of Treatment
06* Expansion of US Veterans' Health Care Choices
09 Capping Federal Medicaid Funding

Joint Report(s)
- CMS / CSAPH Report - Value of Preventive Services

Resolution(s)
101 Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis
102 Establishing a Market System of Health System Financing and Delivery
103 Benefit Payment Schedule
104 Consultation Code Reinstatement
105 Opposition to Price Controls
106 Medical Loss Ratio
107 Repeal and Replace Our Outdated Refundable Advanceable Tax Credit Policy
109 Simplify Medicare Face-to-Face Requirement
110 Over-the-Counter Contraceptive Drug Access
111 VA Technology-Based Eye Care Services
112 CMS Must Publish All Values for Non-Covered and Bundled Services
113 The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services
114 Coverage for Preventive Care and Immunizations
115 Out-of-Network Care
116 Medicare Advantage Payment Policies
117 Expansion of U.S. Veterans' Healthcare Choices
118 Third Party Patient Reimbursement for Out-of-Network Physicians
119 Support Efforts to Improve Access to Diabetes Self-Management Training Services
120 National Pressure Ulcer Advisory Panel Recommendation for Pressure Ulcer Nomenclature Change
121 Advanced Care Planning Codes
122* Reimbursement for Pre-Colonoscopy Visit
123* Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases
124* Emergency Medical Services Reimbursement for On-Site Treatment and Transport to Non-Traditional Destinations
125* Medicaid Substance Use Disorder Coverage
126* Insurance Coverage for Compression Stockings
127* Balance Billing State Regulation
128# Protecting Patients' Access to Emergency Services

* Contained in Handbook Addendum
# Contained in Sunday Tote
Whereas, In a May 19, 2017, letter to customers, Blue Cross Blue Shield of Georgia (BCBS-GA) said that starting July 1 it would no longer cover non-emergency visits to emergency rooms; and

Whereas, BCBS-GA defined emergencies as:

“Emergency” or “Emergency Medical Condition” means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that not getting immediate medical care could result in:

(a) placing the patient’s health or the health of another person in serious danger or, for a pregnant woman, placing the woman’s health or the health of her unborn child in serious danger;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us; and

Whereas, Implementation of such a rule would violate the “prudent layperson standard” established by the ACA; and

Whereas, This is a pattern of behavior amongst other states in which BCBS operates; and

Whereas, Lists containing nearly 2000 diagnoses have been utilized for included emergency services; however, as exclusionary lists these raise the potential to deter patients from seeking emergency care in potentially emergent conditions, such as:

- "Chest pain on breathing" can be a life-threatening pulmonary embolism.
- "Acute conjunctivitis," if caused by gonorrhea, can cause blindness.
- "Influenza," which has killed hundreds of thousands of people over the past century, can be an emergency. Thousands of people die from the flu each year; and

Whereas, A 2013 study published in JAMA reports a nearly 90 percent overlap in symptoms between emergencies and non-emergencies and that ultimately discharge diagnoses are an inappropriate measure of whether the care being sought was of an emergent or life-threatening nature⁴; therefore be it

RESOLVED, That our American Medical Association work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (Directive to Take Action)

Received: 06/09/17

Fiscal Note: Modest: Between $1,000 - $5,000.

Reference Committee B

BOT Report(s)
11 Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging
13 Closing Gaps in Prescription Drug Monitoring Programs
14 Medicare Part B Double Dipping

Resolution(s)
201 Improving Drug Affordability
202 Protect Individualized Compounding in Physicians' Offices
203 AMA to Support Pharmaceutical Pricing Negotiation in US
204 Moved to Reference Committee A (now Resolution 127)
205 Limiting Medicare Part D Enrollee Costs
206 MACRA and the Independent Practice of Medicine
207 Sky Rocketing Drug Prices
208 Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States
209 Reduce Physician Practice Administrative Burden
210 Violation of HIPAA Electronic Transfer Standards by Insurer
211 Sale of Health Insurance Across State Lines
212 Advocacy for Seamless Interface between Physician Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) to be Created and Financed by the Commercial EHR and Dispensing Program Providers
213 Copying and/or Scanning Costs
214 Medical Liability Coverage Through the Federal Tort Claims Act
215 Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act
216 Electronically Prescribed Controlled Substances Without Added Processes
217 Inappropriate Requests for DEA Numbers
218 Licensing of Electronic Health Records
219 Integration of Drug Price Information into Electronic Medical Records
220 Accountability of 911 Emergency Services Funding
221 AMA Policy on American Health Care Act
222 Response to Burdensome Governmental Mandate
223 Tax Deductions for Direct-to-Consumer Advertising
224 Medicare Prepayment and RAC Audit Reform
225 Truth in Advertising
226 Ask CMS and HHS to Remove Practice Expense and Malpractice Expense from Publicly Reported Payments
227 Improving Clinical Utility of Medical Documentation
228 Free Speech Applies to Scientific Knowledge
229* Medicare's Appropriate Use Criteria Program
230* CMS Reimbursement Guidelines for Teaching Physician Supervision
231* Naloxone Price Increase
232* Create MACRA Opt-Out Option
233* Regulation of Physician Assistants
234* Protections for Patients with Genetic Conditions
235* Towards Eliminating ERISA State Preemption of Health Plan Liability

* Contained in Handbook Addendum
# Contained in Sunday Tote
Reference Committee B

Resolution(s)

236* Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising
237* Protection of Clinician-Patient Privilege
238* Limitation on Reports to the National Practitioner Data Bank Unrelated to Patient Care
239* AMA Support for Texting as Approved HIPAA Communication
240* Minimum Federal Standards for Interstate Sale of Health Insurance
241# Timeliness in Obtaining Medical Records from Other Providers
242# Legislation to Require Timely Action on Prior Authorization

* Contained in Handbook Addendum
# Contained in Sunday Tote
Whereas, There exists considerable misunderstanding about HIPAA rules regarding the
permission of releasing a patient’s medical information to another physician without written
authorization; and

Whereas, Some facilities may needlessly delay the release of information vital to the treatment
of the patient by, for example, requiring the completion of unnecessary release paperwork or
rejecting requests which are in fact HIPAA-compliant; and

Whereas, Delays in the release of requested medical information can delay care and leave
physicians with no choice but to duplicate diagnostic tests and consultations; and

Whereas, While AMA policy “urges” and “encourages” physicians and hospitals to share patient
information, including diagnostic findings, there is an evident need for further work on these
processes; therefore be it

RESOLVED, That our American Medical Association work in concert with hospitals, hospital
associations, and accrediting organizations to achieve a universal understanding of HIPAA rules
that allow the transfer of information to members of a patient’s treatment team without written
authorization. (Directive to Take Action)

Fiscal Note: Modest: Between $1,000 - $5,000.

Received: 06/10/17

RELEVANT AMA POLICY

H-155.994 Sharing of Diagnostic Findings

The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent
abstracts of the patients’ medical records, including histories and diagnostic procedures, so that
the hospital physicians sharing in the care of those patients can practice more cost-effective and
better medical care; (2) urges the hospital to return all information on in-hospital care to the
attending physician upon patient discharge; and (3) encourages providers, working at the local
level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to
avoid duplication of expensive diagnostic tests and procedures. (BOT Rep. A, NCCMC Rec. 26,
Whereas, Last year, the AMA convened a workgroup of state and specialty medical societies, national provider associations, and patient representatives to create a set of best practices related to prior authorization and other utilization management requirements; and

Whereas, The workgroup identified the most common provider and patient complaints associated with utilization management programs and developed Prior Authorization and Utilization Management Reform Principles to address these priority concerns; and

Whereas, Although existing AMA policy directs the AMA to strongly urge health plans to apply these principles to their utilization management programs for both medical and pharmacy benefits (AMA Policy D-320.987), state legislatures across the nation have passed, or are taking up, prior authorization legislative remedies that continue to create barriers and potentially unnecessary and dangerous delays to the access of health care; therefore be it

RESOLVED, That our American Medical Association advocate for the initiation of legislation or regulation requiring utilization review entities to provide detailed explanations for prior authorization or step therapy denials (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the initiation of legislation or regulation requiring utilization review entities to make prior authorization or step therapy determinations and to notify providers within 48 hours for non-urgent care. For urgent care, determinations should be made within 24 hours of submission of necessary information (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the initiation of legislation or regulation requiring utilization review entities to communicate decisions on appeals within 10 calendar days. In the event that a provider determines the need for an expedited appeal, utilization review entities should communicate decisions on such appeals within 24 hours (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the initiation of legislation or regulation requiring that all utilization review entity appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider, and (b) was not involved in the initial adverse determination. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000

Received: 06/10/17
RELEVANT AMA POLICY

D-320.987 Prior Authorization Simplification and Standardization
Our AMA will, in collaboration with state medical associations and national medical specialty societies and relevant patient groups, create a set of best practices for PA and possible alternative approaches to utilization control; advocate that accreditation organizations include these concepts in their program criteria; and urge health plans to abide by these best practices in their PA programs and to pilot PA alternative programs. (CMS Rep. 07, A-16)
Reference Committee C

CME Report(s)
01 Council on Medical Education Sunset Review of 2007 House of Delegates Policies
02 Update on Maintenance of Certification and Osteopathic Continuous Certification
03 Obesity Education
06 Standardizing the Allopathic Residency Match System and Timeline
07 Expansion of Public Service Loan Forgiveness
09 Feasibility and Appropriateness of Transferring Jurisdiction Over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools

Resolution(s)
301 Mental Health Disclosures on Physician Licensing Applications
302 Comprehensive Review of CME Process
303 Addressing Medical Student Mental Health Through Data Collection and Screening
304 Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding
305 Reduction of Caregiver Burnout
306 US International Medical Graduates in Physician Workforce
307 Formal Business and Practice Management Training During Medical Education
308 Immigration Reform Impacts on International Medical Graduate Training and Patient Access
309 Future of the USMLE: Examining Multi-Step Structure and Score Usage
310 Breast Pump Accommodations During Medical Licensing Exams
311 Support of International Medical Students and Graduates
312 Supporting International Medical Graduates and Students
313 Study of Declining Native American Medical Student Enrollment
314 Educating a Diverse Physician Workforce
315 Inclusion of Developmental Disabilities Curriculum in Undergraduate, Graduate and Continuing Medical Education of Physicians
316 Action Steps Regarding Maintenance of Certification
317* Immigration
318* Oppose Direct-to-Consumer Advertising of the ABMS MOC Product
319* Public Access to Initial Board Certification Status of Time Limited ABMS Diplomates
320* Cultural Competence in Standardized Patient Programs Within Medical Education
321* Continued Support of H-1B Visa Programs for International Medical Graduates
322* Ending Maintenance of Certification Examinations
323* Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved / Economically Depressed Areas
324# Improve HRSA Projections of the Physician Workforce
325# Ensure an Effective H-1B Visa Program to Protect Patient Access to Care
326# Supporting International Medical Graduates and Students

* Contained in Handbook Addendum
# Contained in Sunday Tote
Whereas, The Health Resources & Service Administration (HRSA), an Agency of the U.S. Department of Health and Human Services (HHS), is the primary federal agency for improving access to health care for the tens of millions of Americans who are medically underserved or face barriers to needed care; and

Whereas, HRSA is responsible for the federal designation of Health Professional Shortage Areas and Medically Underserved Areas/Populations; and

Whereas, A major component of HRSA’s mission is to facilitate and support the recruitment, placement, and retention of primary care and other providers in underserved communities in order to address shortages and improve the distribution of the health workforce; and

Whereas, To assist in the targeting of these efforts and other programs to where they are most needed, HRSA monitors and forecasts long-term health workforce needs, and provides policy makers, researchers, and the public with information on health workforce trends, supply, demand, and policy issues; and

Whereas, HRSA seeks to advance its data collection and data analysis capacity to examine differences in access, quality, and outcomes; and

Whereas, Agency projections of the health care workforce may differ from projections made by other groups including specialty societies, and as an example HRSA predicts a short fall of 280 rheumatologists in 2025, while a recent rheumatology workforce study predicts a gap of 4,000 rheumatologists by 2030\(^1\), a difference of several thousand rheumatologists in a similar time period; and

Whereas, The Centers for Disease Control and Prevention (CDC) released a report showing that the number of Americans living with arthritis is at an all-time high, with 54 million Americans now living with arthritis and other rheumatic diseases, and approximately 79 million will have arthritis by 2040, and other diseases may experience similar prevalence escalations in prevalence; and

Whereas, If lawmakers and other policy makers use HRSA’s numbers to plan graduate medical education slots or other policies, then it would be helpful to have more accurate projections; and

---

Whereas, The availability of more accurate physician workforce numbers may build a stronger case for Congress to approve new Graduate Medical Education (GME) slots, which have been frozen at current levels since 1996; and

Whereas, Disparities in the results of workforce studies may result from the practice of HRSA to not necessarily take into account upcoming changes in retirement rates, disease prevalence, and other variables, instead assuming that such variables may continue at unchanged rates in the future; and

Whereas, Accordingly, HRSA should include in calculations additional details of variables such as disease epidemiology trends, workforce retirement projections, and projections of the amount of time new health care providers will work; therefore be it

RESOLVED, That our American Medical Association work with the Health Resources & Service Administration and specialty societies to determine specific changes that would improve the agency’s physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/19/17

RELEVANT AMA POLICY

Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that: (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.

(2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.

(3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.

(4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.

(5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.

(6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.

(7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.

See also:
US Physician Shortage H-200.954
Supply and Distribution of Health Professionals H-200.987
Physician Workforce Planning and Physician Retraining D-305.995
Designation of Areas of Medical Need H-200.992
WHEREAS, Approximately 15,000 physicians have provided medical care for Americans through H-1B visas since 2003; and

WHEREAS, The U.S. Citizenship and Immigration Services (USCIS) temporarily suspended the use of premium processing for H-1B petitions beginning April 3, 2017; and

WHEREAS, The suspension of the premium processing option will be disruptive not only for the individual beneficiaries of these petitions, but in particular, the many medical professionals and the rural and underserved communities they serve throughout the United States; and

WHEREAS, The temporary suspension of the H-1B premium processing option is likely to exacerbate substantial access problems patients are already facing across this country, with profound effects on patient care in rural and other underserved areas of the United States; and

WHEREAS, Hospitals and medical practices across the country that already suffer from acute staffing shortages will have even greater difficulty obtaining medical residents/fellows if they are prevented from using premium processing to hire new residents in time for the beginning of their programs this July 1; and

WHEREAS, The lack of premium processing also impacts medical practices and hospitals seeking to extend the status of their current doctor/medical professional staff, and physicians who complete their training on June 30; and

WHEREAS, A six-month suspension of premium processing will impact virtually all the medical professionals applying to work in underserved areas of our nation, with severe impacts felt as soon as this July; therefore be it

RESOLVED, That our American Medical Association proactively work with appropriate officials to secure an exemption of medical professionals from the suspension of and any future modifications to the H-1B visa program, in order to allow for efficient entry of international physicians into the United States. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/22/17

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFCMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA’s representatives to the ECFCMG Board of Trustees.
6. The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.
7. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
8. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
9. The AMA continues to support the activities of the ECFCMG related to verification of education credentials and testing of IMGs.
10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
11. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
12. That AMA representatives to the ACGME, residency review committees and to the ECFCMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
13. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
14. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
20. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
22. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
23. Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.
24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFCMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Resolution: 325 (A-17)
Resolution: 326  
(A-17)

Introduced by: Young Physicians Section

Subject: Supporting International Medical Graduates and Students

Referred to: Reference Committee C  
(Kenneth Certa, MD, Chair)

Whereas, On January 27, 2017, President Trump signed Executive Order 13769, which banned citizens/nationals of seven Middle Eastern countries from entering the United States; and

Whereas, The aforementioned executive order prevented many of our colleagues from returning to the United States to practice; and

Whereas, The order was issued in the middle of residency application season after most interviews were complete, ruining the chances of many international medical graduates from entering residencies and fellowships for the foreseeable future and potentially resulting in unfilled residency spots, which will decrease the quality of care for our patients; and

Whereas, According to studies performed by the Association of American Medical Colleges (AAMC), there is currently a shortage of physicians in America, which will likely be worsened if fewer International Medical Graduates and Students are allowed to immigrate to the United States; and

Whereas, Several other medical societies including the American College of Physicians and the AAMC have come out in opposition to Executive Order 13769; and

Whereas, On March 6, 2017, President Trump rescinded Executive Order 13769, and replaced it with Executive Order 13780, which still bans the issuance of new visas for citizens/nationals of six Middle Eastern countries; therefore be it

RESOLVED, That the American Medical Association oppose laws and regulations that would broadly deny entry or re-entry to the United States by persons based on their country of origin and/or religion who currently have legal visas, including permanent resident status (green card) and student visas (New HOD Policy); and be it further

RESOLVED, That the AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 06/09/2017

RELEVANT AMA POLICY
H-200.950 Retraining Refugee Physicians
Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories. (BOT Rep. 20, A-10)

D-255.985 Conrad 30 - J-1 Visa Waivers
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program. 2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program. 3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs. 4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses. 5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria. (Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11 Modified: BOT Rep. 5, I-12)

References:
5. https://www.acponline.org/acp-newsroom/acp-comprehensive-statement-us-immigration-policy
Reference Committee D

CSAPH Report(s)
03 Strategies to Reduce the Consumption of Beverages with Added Sweeteners

Resolution(s)
401 Use of Phrase "Gun Violence Mitigation" in Lieu of "Gun Control"
402 Destigmatizing Obesity
403 Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking
404 Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons
405 Decreasing Screen Time and Increasing Outdoor Activity to Offset Myopia Onset and Progression in School Children
406 Healthful Hospital Foods
407 SNAP Reform to Improve Health and Combat Food Deserts
408 Increased Oversight of Suicide Prevention Training for Correctional Facility Staff
409 Pediatric/Adolescent Informed Consent Concussion Discussion
410 Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals
411 Preserving Vaccine Policy in the United States
412 Domestic Water Testing for Lead Toxic Kids
413 Ocular Burns from Liquid Laundry Packets
414 Imposing Taxes on Sugar-Sweetened Beverages
415* Food Bank and Pantry Distribution of Nutrient-Dense Foods
416* Policy and Economic Support for Early Child Care
417* Mandatory Public Health Reporting of Law Enforcement Related Injuries and Death
418# Policy on Quarantine
419# Improving Physicians' Ability to Discuss Firearm Safety

* Contained in Handbook Addendum
# Contained in Sunday Tote
Whereas, the term “quarantine” is broadly defined as (1) a strict isolation imposed to prevent the spread of disease; (2) a period, originally 40 days, of detention or isolation imposed upon ships, persons, animals on arrival at a port (or place) when suspected of carrying some infectious or contagious disease; (3) a system of measures maintained by governmental authorities for the prevention of a disease; and

Whereas, a quarantine separates and restricts the movement of people who could have been exposed to a contagious disease; and

Whereas, quarantine stations are currently located at 20 ports of entry and land-border crossings where international travelers arrive; and

Whereas, these stations are staffed with quarantine medical and public health officers from the Centers for Disease Control and Prevention (CDC); and

Whereas, these health officials decide whether possibly contagious individuals can enter the United States and what measures should be taken to prevent the spread of infectious diseases; and

Whereas, on January 19, 2017, the CDC issued new regulations that gave it broad authority to quarantine individuals; and

Whereas, these regulations outline how the federal government can restrict interstate travel during a health crisis, and establishes in-house oversight (with up to three layers of internal agency review) of whether someone should be detained, without providing a clear and direct path to challenge a quarantine order; and

Whereas, this internal review has no explicit time limit and could easily stretch on for weeks (and months) while a “possibly” healthy person remains in quarantine; and

Whereas, until now, most quarantines have been imposed by states and local governments, which have the primary responsibility for protecting the health of their population; and

Whereas, the new administration now has even more authority to detain people; and

Whereas, prompt judicial review has always been important during an epidemic, usually allowing people to challenge an order of quarantine; and
Whereas, The CDC now has clear authority to take over the quarantine role from states; and

Whereas, Quarantine regulations are now being imposed based in part, on non-medical reasons, rather than scientific knowledge and findings; therefore be it

RESOLVED, That our American Medical Association adopt policy acknowledging that government quarantines are developed based on evidence-based medicine and have strong due process protections (New HOD Policy); and be it further

RESOLVED, That our AMA support that the medical profession collaborate with federal, state and local public health officials to take an active role in ensuring that quarantine and isolation interventions are evidence based. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/28/17
Whereas, Suicide is a serious public health concern, with firearms, particularly handguns, being the most common means of suicide in the United States; and

Whereas, Research suggests that up to 45% of individuals who die by suicide have visited their primary care physician in the month prior to their death and up to 67% of those who attempt suicide receive medical attention as a result of their attempt; and

Whereas, Patients trust their physicians to advise them on issues that affect their health, and physicians have the ability to answer questions and educate their patients on firearm safety; and

Whereas, In addition to its long-standing policy in support of the rights of physicians to have free and open communication with their patients regarding firearm safety and initiatives to enhance access to mental and cognitive health care, the AMA remains vigorous in its efforts to oppose legislation seeking to limit physician speech on firearms (AMA Policies H-373.995, H-145.976, and H-145.975); and

Whereas, Despite the AMA’s ongoing advocacy efforts, physicians continue to face a number of barriers in communicating with patients about firearm safety, including uncertainty about when and how to speak with patients, as well as concerns about regulations that prohibit physicians from asking patients about firearms or that require disclosure of confidential patient information to third parties; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related accidental injury or death by suicide, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties. (Directive to Take Action)

Fiscal Note: Estimated cost of $25,000 to implement resolution.

Received: 06/10/17

RELEVANT AMA POLICY

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging
physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. (Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16)

H-145.976 Firearm Safety Counseling in Physician-Led Health Care Teams
Our AMA: (1) will oppose any restrictions on physicians’ and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (2) will oppose any law restricting physicians’ and other members of the physician-led health care team’s discussions with patients and their families about firearms as an intrusion into medical privacy; and (3) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education. (Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13)

H-373.995 Government Interference in Patient Counseling
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
   A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
   B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
   C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
   D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
   E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
   F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
   G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States. (Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15)
Reference Committee E

CSAPH Report(s)

01 CSAPH Sunset Review of 2007 Policies
02 Emerging Drugs of Abuse are a Public Health Threat

Resolution(s)

501 Airplane Emissions
502 Access to Cosmetic Product Ingredients
503 Women and Mental Health
504 Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women
505 Recognition of Sepsis in the Community
506 Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder
507 Educating Physicians and Young Adults on Synthetic Drugs
508 Support for Service Animals, Emotional Support Animals, Animals in Healthcare and Medical Benefits of Pet Ownership
509 Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research
510 Ban on the Use of Paraquat
511 Future of Pain Care
512 Advertising Restrictions and Limited Use of Dietary Supplements
513 Supervised Injection Facilities
514 Retinoblastoma Due to Pre-Natal Residential Pesticide Exposure
515 Safe Use, Storage and Disposal of Leftover Opioids and Other Controlled Substances
516 In-Flight Emergencies
517 Choline Supplementation in Prenatal Vitamins
518 Recognition of Infertility as a Disease
519* Liquid Medication Dosing
520* Combination Clotrimazole/Betamethasone Diproprionate Cream Warning
521* Retail Prescription Bottle Label Privacy
522# National Coordinated Strategy for Sepsis
523# AMA Support for Evidence-Based Environmental Statutes and Regulations
524# Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis
525# Providing for Prescription Drug Donation
526# NIH Funding for Basic and Translational Pain Research

* Contained in Handbook Addendum
# Contained in Sunday Tote
Whereas, Sepsis is a leading cause of deaths in hospitals and a leading cause of preventable death in children\(^1\); and

Whereas, Sepsis affects more than 1 million Americans each year\(^2\) at an annual cost of over $20 billion\(^1\); and

Whereas, Suspecting, diagnosing, and treating sepsis promptly appears to increase patient survival\(^1,2,3,4,5\), although the specifically beneficial measures are not completely certain\(^5,6,7\); and

Whereas, It is estimated that 55% of, at least pediatric, sepsis starts in outpatient settings\(^2\); and

Whereas, Sepsis may be difficult to recognize in outpatient and emergency settings\(^1\); and

Whereas, There is significant scientific uncertainty about the best case definition of sepsis for treatment and surveillance purposes\(^3,4\); and

Whereas, States such as New York and Illinois have mandated fixed and specific protocols for sepsis diagnosis and treatment, and other states such as Pennsylvania are looking at such legislation or have had legislation introduced; and

Whereas, State-mandated sepsis protocols may be implemented without structured trials designed to identify unforeseen costs and potential patient harms, and may be subject to commercial pressures\(^7\); and

Whereas, The practice of externally prescribing specific medical protocols may discourage needed research, and may lead to inaccurate diagnoses and inappropriate treatments when patients with or without sepsis have cases with unusual presentations; and

---


Whereas, Payors such as the Centers for Medicare & Medicaid Services (CMS) have proposed overly specific diagnostic and treatment protocols for suspected sepsis; and

Whereas, Additional payors and health systems may institute sepsis protocols of their own, especially if and when CMS finalizes its proposed measures; and

Whereas, Physician leadership is necessary in order to protect patients and to maintain our profession’s autonomy; therefore be it

RESOLVED, That our American Medical Association support innovations that facilitate the early recognition and treatment of sepsis (New HOD policy); and be it further

RESOLVED, That our AMA study current and proposed sepsis policies, and make recommendations for the evidence-based policies that appear most likely to reduce morbidity and mortality from sepsis (Directive to Take Action); and be it further

RESOLVED, That our AMA report its findings, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/31/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution: 523
(A-17)

Introduced by: Arizona

Subject: AMA Support for Evidence-Based Environmental Statutes and Regulations

Referred to: Reference Committee E (Rebecca S. Hierholzer, MD, Chair)

Whereas, Since the early 1970's the Environmental Protection Agency (EPA), Clean Air and Clean Water Acts have protected our environment and by extension our public health; and

Whereas, The EPA should be guided by science when crafting and implementing policy and should always be advocates for the health and welfare of the American people and the environment; and

Whereas, Existing national statutes and regulations intended to regulate air and water pollution, and to reduce greenhouse gas emissions, should not be modified without scientific justification; therefore be it

RESOLVED, That our American Medical Association strongly support evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that environmental health regulations should only be modified or rescinded with scientific justification. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 06/06/17
Whereas, The prevalence of heroin dependence increased by 90% between the period of 2002-2004 and that of 2011-2013\(^1\), and the number of deaths attributed to heroin injection overdoses have quadrupled nationally since 2010\(^2,3\); and

Whereas, Persons who inject drugs (PWID) are more likely to contract infectious diseases like HIV, hepatitis C, and soft tissue infections\(^4,5\); and

Whereas, Supervised injection facilities (SIFs) are sites that “allow PWID to inject self-provided drugs within a supervised framework in enhanced aseptic conditions with medical monitoring and no risk of police control”\(^6\); and

Whereas, In areas where they are established, SIFs reduce the number of overdose deaths\(^7\), reduce transmission rates of infectious disease\(^8,9\), increase the number of individuals initiating substance use therapy\(^10,11\), improve access to care for those that would not otherwise access the health care system\(^6,12,13,14\), and to date have had no documented fatalities\(^11,12,17\); and

Whereas, SIFs effectively attract and provide services for PWID who are at greatest risk due to homelessness, daily use, and recent nonfatal overdose\(^12,17\), and it has been shown that youth in high-risk categories are more likely to use SIFs\(^18,19\); and

---


Whereas, SIFs do not increase overall illicit drug use, encourage drug use, or promote first-time drug experimentation\textsuperscript{10,20}; and

Whereas, North America’s only currently existing SIF has created significant healthcare savings due to averted infections and deaths, and cost-benefit projections for potential SIFs in other North American cities have predicted similarly favorable results\textsuperscript{21,22,23}; and

Whereas, Multiple state legislatures and localities are currently involved in efforts to create legal frameworks for and facilitate the creation of SIFs or similar facilities to further combat the opioid addiction crisis\textsuperscript{26,27,28,29}, therefore be it

RESOLVED, That our American Medical Association work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000

Received: 06/10/17

RELEVANT AMA POLICY:

Harm Reduction Through Addiction Treatment H-95.956

The AMA endorses the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of alcoholism and other drug dependencies and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy.

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (2) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical

\begin{thebibliography}{9}
\end{thebibliography}
judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999
Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Syringe and Needle Exchange Programs H-95.958
Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

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

---

29 Massachusetts Senate Bill 1081. https://malegislature.gov/Bills/190/SD1775.Html
Whereas, There exists a patchwork of state laws prohibiting or permitting to varying degrees the recycling or donation of unused prescription drugs; and

Whereas, Even in those states with laws permitting recycling or donation of unused prescription drugs, many do not have operational programs; and

Whereas, Patients who are uninsured or underinsured stand to benefit substantially from the availability of donated drugs, especially those requiring access to expensive cancer-fighting drugs; and

Whereas, Nursing homes are a prime source for unused prescription drugs that, absent recycling or donation programs, would go to waste; therefore be it

RESOLVED, That our American Medical Association advocate for new federal legislation that would allow nursing homes to recycle prescription drugs that are unused, sealed, and dated (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for new federal legislation that would allow physician offices and clinics to donate prescription drugs that are unused, sealed, and dated to patients in need who are uninsured or underinsured (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for new federal legislation that would allow cancer programs and clinics to accept and recycle cancer-specific drugs to patients in need who are uninsured or underinsured. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 - $5,000 to implement resolution.

Received: 06/10/17
Whereas, Chronic pain has multiple physiological and psychosocial dimensions, and at times, there may not be an apparent injury or sustained cause for chronic pain; and

Whereas, Despite their poorly defined and unpredictable effects on chronic pain, opioid prescription drugs remain the default treatment for chronic pain and has been recognized as the principal cause of the opioid epidemic; and

Whereas, Safe, effective, and affordable pain therapies are urgently needed to replace opioids, prevent the shift from acute-level pain to a chronic condition, and significantly reduced U.S. pain cost and the national deficit–but the development of transformative therapies relies on NIH funded research discoveries; and

Whereas, Federal attention to the problem of pain has grown recently with the creation of a number of governmental agencies that have advanced measures to counter opioid over-use, yet compared to other diseases, pain research remains significantly underfunded relative to societal costs; and

Whereas, The President’s Commission on Combating Drug Addiction and the Opioid Crisis completes its fact finding period on June 26, 2017, and NIH Director Francis Collins has recently initiated a public private partnership to address opioids and pain; therefore be it

RESOLVED, That our American Medical Association actively advocate for increased funding, and monitor other efforts to expand funding, for the National Institutes of Health (NIH) specifically for basic and translational pain research, with regular updates to AMA membership (Directive to Take Action); and be it further

RESOLVED, That our AMA submit supportive testimony on behalf of increased funding for basic and translational pain research at the President’s Commission on Combating Drug Addiction (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for current legislation that will increase funding for basic and translational pain research. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000

Received: 06/10/17
### Reference Committee F

**BOT Report(s)**
- 01 Annual Report
- 04 AMA 2018 Dues
- 10 Creation of an AMA Fund for Physician Candidates
- 16# Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere (REVISED)
- 17 Equality for Future Meetings Organized or Sponsored by the AMA
- 23* Anti-Harassment Policy

**HOD Comm on Compensation of the Officers**
* Report of the House of Delegates Committee on Compensation of the Officers

**Resolution(s)**
- 601 Reinstate the AMA Commission to End Health Care Disparities
- 602 Studying Healthcare Institutions that Provide Child Care Services
- 603 Sexual Orientation and Gender Identity Demographic Collection by the AMA
- 604 High Cost to Authors for Open Source Peer Reviewed Publications
- 605 Pronunciation of Pharmaceutical Names
- 606* Add Patients to the AMA Mission Statement
- 607# AMA to Protect Human Health from the Effects of Climate Change by Ending Its Investments in Fossil Fuel Companies (Divestment)
- 608# Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine
- 609# Model Hospital Medical Staff Bylaws

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

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

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

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

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

DISCUSSION:

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

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

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

The AMA has extensive policy on public health issues as well as multiple other policies impacting
the health of our patients and physician practice. While the Board recognizes gun violence as a
major public health issue they also believe there are a number of other high priority AMA policies.

It would be difficult if not impossible to monitor the compliance of states or cities with AMA
policy and move meeting venues accordingly.

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

CONCLUSION:

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

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

RECOMMENDATION:

Given that the Board and management will be alert to “gun gag” laws and similar types of laws
when selecting future meeting sites even without a specific rigid policy, the Board of Trustees
recommends that Resolution 604-I-16 not be adopted and the remainder of the report be filed.
WHEREAS, The Intergovernmental Panel on Climate Change has concluded that the burning of fossil fuels by humans to generate energy is the principal driver of climate change. Burning fossil fuels is already causing accelerated warming of Earth’s surface, which is a direct threat to both environmental and human health; and

WHEREAS, The burning of fossil fuels, such as coal, petroleum derivatives, and natural gas, is recognized by the AMA to be detrimental to human health and to contribute significantly to global climate change; and

WHEREAS, AMA policies favor environmental education and stewardship (AMA Policies H-135.973, H-135.969, H-135.939) and the need for improved energy efficiency in our offices and medical centers (D-155.999), and other aspects of environmental sustainability, but these policies do not address the investment and business strategies of health professionals, professional organizations, and hospitals; and

WHEREAS, Our AMA recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public (H-135.938); and

WHEREAS, Our AMA recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes (H-135.938); and

WHEREAS, In recent years, divestment of fossil fuel companies by healthcare organizations has been initiated by Gundersen Health, a well-known health system based in Wisconsin; by HESTA Australia, a health care industry retirement fund worth $26 billion; and by the British Medical Association; and

WHEREAS, As physicians who have committed to the principle of “First do no harm”, we share an ethical obligation to minimizing fossil fuel consumption in our daily activities, and to strive to influence the health care institutions within which we practice and our professional societies to divest from fossil fuels; therefore be it

RESOLVED, That our American Medical Association, Foundation, and any affiliated corporations, work in a timely and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (Directive to Take Action); and be it further
RESOLVED, That our AMA, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policy makers. (New HOD Policy)

Fiscal Note: Indeterminate.

Received: 05/31/17

RELEVANT AMA POLICY

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.


Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Citation: (Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)
Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.
Citation: CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16;

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
Citation: (CSAPH Rep. 3, I-08; Reaffirmation A-14)

Energy Efficiency and Medical Practice D-155.999
Our AMA will urge its individual members and organizational affiliates to participate in energy efficiency activities in all medical facilities including hospitals, clinics, offices and research facilities.
Citation: (Res. 413, I-98; Reaffirmed: CLRPD Rep. 1, A-08)
Whereas, Significant changes are occurring in the practice of medicine; and

Whereas, Physician leadership and engagement are necessary to assure that interests of patients and the medical profession are well served now and in the future; and

Whereas, Medical schools and teaching hospitals play a critical role in the education of young physicians; and

Whereas, Academic physicians and teaching physicians play a critical role in professional development of young physicians, serving as role models for patient advocacy and legislative engagement; and

Whereas, There are opportunities for advocacy and legislative action in our AMA and the state and county medical societies (organized medicine); and

Whereas, A significant number of new (and established) medical schools use community-based faculty and community hospitals for medical student education; therefore be it

RESOLVED, That our American Medical Association study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine on medical school campuses and in teaching hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine at the training sites. (Directive to Take Action)

Fiscal Note: Modest: Between $1,000 - $5,000.

Received: 06/10/17
RELEVANT AMA POLICY

Greater Involvement of Medical Students in Federation Organizations G-620.050
Our AMA encourages medical societies to provide mechanisms for more direct involvement of students at the state and local levels, and to implement membership options for their state's medical students who are enrolled in medical school for longer than four years. Our AMA will work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years. (CCB/CLRPD Rep. 3, A-12)

Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994

Employed Physicians and the AMA G-615.105
1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Res. 601, I-11)

Federation Organizations and Organized Medical Staff G-620.080

Enhancing the Value of Membership in Organized Medicine G-620.060
The perspective of our AMA House on enhancing the value of membership in organized medicine includes the following: (1) The House adopts the goal of improving Federation performance as a whole; (2) The House supports efforts to improve the Federation's business processes to include a new member early recognition and retention system and consolidated billing and application process; (3) The House supports the redesign of Federation products and pricing to increase overall appeal and thus recruit additional members and improve retention; (4) The House believes that the Federation should work together to leverage each organization's core competencies; (5) The House encourages the testing of different strategic and operational collaborative arrangements at many sites and the use of these to improve Federation membership, pricing, and member service; (6) The House encourages state medical associations and national medical specialty societies to review the composition of their AMA delegations; (7) The House believes it is important to promote resident physician membership in national medical specialty societies; (8) The House urges all county and state societies to implement a simple transfer of membership procedure to permit uninterrupted membership in organized medicine for physicians who relocate at any time during their careers, with such procedure containing the flexibility to permit resident AMA members to become regular state and county members through the transfer process; and (9) The House encourages medical associations and societies to support the membership efforts of the Alliance, particularly if dual membership billing is utilized, and, with the state and county associations, supports and acknowledges the efforts of our AMA Alliance and state and county medical alliances, whenever it is deemed possible and appropriate. (CLRPD Rep. B, A-83 Sub. Res. 174, A-88 Res. 608, A-92 Reaffirmed: CLRPD Rep. I-93-1 BOT Rep. 23, I-97 Reaffirmed: Sunset Report, I-98 Consolidated: CLRPD Rep. 3, I-01 Reaffirmed: CC&B Rep. 2, A-11)
Whereas, The AMA developed the *Physician’s Guide to Medical Staff Organization Bylaws* as a reference manual for medical staffs in drafting or amending bylaws, and as a resource on emerging issues in health care that impact the medical staff; and

Whereas, Although the *Guide* provides sample bylaw language that supports self-governance, it is not a model bylaws document; and

Whereas, A complete set of “model bylaws,” continuously updated to meet hospital accreditation and state law requirements, as well as Medicare Conditions of Participation, would provide a valuable companion piece to the *Guide*; therefore be it

RESOLVED, That our American Medical Association:

1. Develop model hospital medical staff bylaws that incorporate currently believed to be best practices, meet the requirements of the Medicare Conditions of Participation, hospital accreditation organizations with deeming authority, and state laws and regulations, including annotations to show the source of all legal, regulatory, and accreditation requirements; and

2. Post this resource on the AMA website, continuously updated and available on demand to medical staffs, medical staff offices, and medical society staff, and widely distributed as an adjunct to the next edition of the *AMA Physician’s Guide to Medical Staff Bylaws* (Directive to Take Action); and be it further

RESOLVED, That our AMA ask the legal counsels of State Medical Societies to outline state specific restrictions of medical staff self governance so that these may be posted on the AMA-OMSS website for use by all AMA members. (Directive to Take Action)

Fiscal Note: Approximately $100,000 upfront cost, plus $36,000 per year to maintain

Received: 06/10/17
Reference Committee G

BOT Report(s)
09  Physician and Medical Staff Member Bill of Rights
12  Unforeseen Consequences of Core Measures
18  Eliminate the Requirement of H&P Update
20  Study of Minimum Competencies and Scope of Medical Scribe Utilization

CMS Report(s)
04  Survey of Addiction Treatment Centers' Availability
05  Hospital Consolidation
07  Retail Health Clinics
08  Prior Authorization and Utilization Management Reform
10  Physician-Focused Alternative Payment Models: Reducing Barriers

Resolution(s)
701  Third Party Payers Mandating Doctor and Patient Transfers of Prescriptions
702  Credentials / Specialty Added to Clinical Note Signatures
703  Certified Translation Services
704  Prior Authorization Abuse
705  Regulating Health Plans Medical Advice
706  Concurrent and Overlapping Surgery
707  Inclusion of Continuing Care Retirement Centers & Long-Term Care Facilities in Accountable Care Organizations Investment Model
708  Removing ‘Three Star Minimum’ Requirement for Skilled Nursing Facilities to Participate in Next Gen Accountable Care Organizations & Bundled Payments for Care Improvement Programs and Care for Patients with Waiver of Three Night Hospital Stay Requirement
709  Management of Physician and Medical Student Stress
710  Payment for Medicaid Interpreter Services
711  Expanding Access to Screening Tools for Social Determinants of Health
712*  Pay-for-Performance Incentives
713*  Urge AMA to Release a White Paper on ACOs
714*  Timely Referral to Pain Management Specialist
715*  Prescription Availability for Weekend Discharges
716*  Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records
717*  Allowing Exceptions to the Centers for Medicare & Medicaid Services' Locum Tenens 60-Day Limit
718#  Developing Physician Leadership in the Implementation of Diagnostic Error Surveillance
719#  System Approach to Medical Staff Governance
720#  Medical Staff Non-Punitive Reporting Processes
721#  Secret Ballots in Medical Staff Voting Processes

* Contained in Handbook Addendum
# Contained in Sunday Tote
American Association of Public Health Physicians

Subject: Developing Physician Leadership in the Implementation of Diagnostic Error Surveillance

Resolved by: Reference Committee G

Whereas, Diagnosing disease, at an individual or community level, is a core competency of being a physician in almost every specialty; and

Whereas, Diagnostic error is estimated to contribute to 10% of patient deaths and 6-17% of avoidable adverse events in hospitals, with additional consequences in other care settings; and

Whereas, Diagnostic error was identified in 2000 in the landmark “To Err is Human” report; and

Whereas, The National Academy of Medicine (formerly the Institute of Medicine) defined “diagnostic error” as “the failure to (a) establish an accurate and timely explanation of the patient’s health problem(s) or (b) communicate that explanation to the patient”, in the 2015 report on Improving Diagnosis in Health Care; and

Whereas, Recognizing the complexity of diagnostic systems, the National Academy of Medicine emphasized that, “a sole focus on diagnostic error reduction will not achieve the extensive change necessary; a broader focus on improving diagnosis is warranted”; and

Whereas, System issues that lead to physician burn out, overwork, or ineffective support systems can affect a physician’s ability to make a correct diagnosis; and

Whereas, The National Academy of Medicine report makes recommendations for system improvement, so that all clinicians’ diagnostic performance can be improved; and

Whereas, Consistent with previous AMA Policy H-450.966 and H-335.965, the AMA has a role in the leadership of quality management; and

Whereas, Recognizing that oversight of this core physician process will be coming and can be used by insurance companies and others that may not favor physician practices, our AMA needs to provide leadership by taking ownership of this measure; and


Whereas, To provide leadership, our AMA must be more than simply at the table, our AMA must have a direction and our AMA is the best organization to devise a direction that will protect physician practices and allow good physician care to thrive; therefore be it
RESOLVED, That our American Medical Association endorse the recommendations of the Improving Diagnosis in Health Care report published by the National Academy of Medicine in 2015 (New HOD Policy); and be it further
RESOLVED, That our AMA support having physician satisfaction with administrative and support systems as a standard measure when assessing diagnostic error (New HOD Policy); and be it further
RESOLVED, That our AMA analyze from a policy perspective how best to position physicians in what may be increasing review of a physician’s diagnostic skills (Directive to Take Action); and be it further
RESOLVED, That our AMA report the findings of this analysis, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/31/17

RELEVANT AMA POLICY

Patient Safety H-335.965 - Our AMA: (1) continues its advocacy efforts in the area of patient safety and work to promote a meaningful long-term approach to ensure greater patient safety in the delivery of health care in our nation; and (2) continues to advance non-punitive, evidenced-based health systems error data collection as well as strong legal protections for participants in safety programs. At a minimum, these protections must ensure that all information reported or otherwise gathered in the process of patient safety and error reporting programs (including any data, report, memorandum, analysis, statement, or other communication) intended either for internal use, or to be shared with others solely for the same purposes, remain confidential and not be subject to discovery in legal proceedings. Such protections must extend from the time of reporting to post-incident review activities and with regard to the repositories of identifiable data from such reporting programs. Citation: (Sub. Res. 202, A-00; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-05; Modified: CSAPH Rep. 1, A-15)

Quality Management H-450.966 - The AMA: (1) continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. Citation: BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed i lieu of Res. 714, A-14; Reaffirmed in lieu of Res. 814, I-14; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmed: BOT Rep. 20, A-16;
Whereas, In 2014, the Centers for Medicare and Medicaid Services issued final revisions to the Medicare Conditions of Participation that allow for a unified and integrated medical staff to be shared by multiple hospitals within a health care system; and

Whereas, The process of adopting a unified medical staff is a challenging undertaking that requires significant political capital and has the potential to create distrust and animosity within the medical staff, which may ultimately outweigh the benefits of unification; and

Whereas, Rather than full unification, many hospital systems have shifted towards a system approach to medical staff governance through the institution of system-level leadership structures and standardization of medical staff bylaws; and

Whereas, While this approach in part affords hospital systems many of the benefits of formal unification without having to dissolve established medical staff governance, further guidance is needed to educate medical staff and hospital leaders on all of the potential benefits and risks of implementing this system approach and whether such an approach might be appropriate for their organizations; therefore be it

RESOLVED, That our American Medical Association provide guidance to medical staffs on the potential benefits and risks of applying a system approach to medical staff governance, including but not limited to guidance on instituting system-wide processes and leadership structures and otherwise standardizing medical staff bylaws. (Directive to Take Action)
Whereas, A physician’s professional commitment to advance scientific knowledge and make relevant information available to patients, colleagues, and the public carries with it the responsibility to report adverse events (AMA Ethical Opinion 8.6 and 8.8); and

Whereas, Retaliation against a physician for reporting deficiencies in the quality, safety, or efficacy of patient care threatens not only that physician’s livelihood, but also the care of all patients; and

Whereas, Our AMA strongly supports efforts to prohibit hospitals and other healthcare organizations from taking action, or threatening to take action, against medical staff members who report deficiencies in the quality, safety, or efficacy of patient care (AMA Policy H-435.942); and

Whereas, While existing AMA policy seeks to eliminate the negative repercussions for medical staff members who report problems within their workplace, medical staffs require further guidance on how to implement reporting approaches that effectively protect staff members from retaliation; therefore be it

RESOLVED, That our American Medical Association provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000

Received: 06/10/17

RELEVANT AMA POLICY

H-435.942 Fair Process for Employed Physicians
1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity.
2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace. (Res. 007, I-16)

AMA Ethical Opinion 8.6 Promoting Patient Safety
In the context of health care, an error is an unintended act or omission or a flawed system or plan that harms or has the potential to harm a patient. Patients have a right to know their past and present medical status, including conditions that may have resulted from medical error. Open communication is fundamental to the trust that underlies the patient-physician relationship, and physicians have an
obligation to deal honestly with patients at all times, in addition to their obligation to promote patient
welfare and safety. Concern regarding legal liability should not affect the physician’s honesty with the
patient. Even when new information regarding the medical error will not alter the patient’s medical
treatment or therapeutic options, individual physicians who have been involved in a (possible) medical
error should:

(a) Disclose the occurrence of the error, explain the nature of the (potential) harm, and provide the
information needed to enable the patient to make informed decisions about future medical care.
(b) Acknowledge the error and express professional and compassionate concern toward patients
who have been harmed in the context of health care.
(c) Explain efforts that are being taken to prevent similar occurrences in the future.
(d) Provide for continuity of care to patients who have been harmed during the course of care,
including facilitating transfer of care when a patient has lost trust in the physician.

Physicians who have discerned that another health care professional (may have) erred in caring for a
patient should:

(e) Encourage the individual to disclose.
(f) Report impaired or incompetent colleagues in keeping with ethics guidance.

As professionals uniquely positioned to have a comprehensive view of the care patients receive,
physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and
preventing medical errors. Both as individuals and collectively as a profession, physicians should:

(g) Support a positive culture of patient safety, including compassion for peers who have been
involved in a medical error.
(h) Enhance patient safety by studying the circumstances surrounding medical error. A legally
protected review process is essential for reducing health care errors and preventing patient harm.
(i) Establish and participate fully in effective, confidential, protected mechanisms for reporting
medical errors.
(j) Participate in developing means for objective review and analysis of medical errors.
(k) Ensure that investigation of root causes and analysis of error leads to measures to prevent future
occurrences and that these measures are conveyed to relevant stakeholders. (AMA Principles of
Medical Ethics: I,II,III,IV,VII)

AMA Ethical Opinion 8.8 Required Reporting of Adverse Events

Physicians’ professional commitment to advance scientific knowledge and make relevant information
available to patients, colleagues, and the public carries with it the responsibility to report suspected
adverse events resulting from the use of a drug or medical device.

Mandated pre- and post-marketing studies provide basic safeguards for public health, but are inherently
limited in their ability to detect rare or unexpected consequences of use of a drug or medical device. Thus
spontaneous reports of adverse events, especially rare or delayed effects or effects in vulnerable
populations are irreplaceable as a source of information about the safety of drugs and devices. As the
professionals who prescribe and monitor the use of drugs and medical devices, physicians are best
positioned to observe and communicate about adverse events.

Cases in which there is clearly a causal relationship between use of a drug/device and an adverse event,
especially a serious event, will be rare. Physicians need not be certain that there is such an event, or
even that there is a reasonable likelihood of a causal relationship, to suspect that an adverse event has
occurred. A physician who suspects that an adverse reaction to a drug or medical device has occurred
has an ethical responsibility to:

(a) Communicate that information to the professional community through established reporting
mechanisms.
(b) Promptly report serious adverse events requiring hospitalization, death, or medical or surgical
intervention to the appropriate regulatory agency. (AMA Principles of Medical Ethics: I,V, VII)
Whereas, Our AMA has long recognized a physician’s unfettered right to exercise his or her personal and professional judgment in voting on any matter regarding patient care interests, the profession, health care in the community, and other medical staff affairs (AMA Policy H-225.952); and

Whereas, AMA policy further supports the right of physicians to not be retaliated against by their employers for asserting the foregoing rights; and

Whereas, The use of secret ballots allows the choices of each voting member of the medical staff to remain anonymous, forestalling any attempts to influence, intimidate, or retaliate against individual members; therefore be it

RESOLVED, That our American Medical Association advocate for the use of secret ballots by medical staffs in all decision-making matters where voting members of the medical staff may be unwilling to publicly vote due to employer or other pressures that could impact how individual members vote (New HOD Policy); and be it further

RESOLVED, That our AMA provide guidance to help organized medical staffs develop and implement secret balloting processes, including specific procedures that allow for individual members of the medical staff to confidentially request a vote by secret ballot. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000